



Durham Research Online

Deposited in DRO:

27 March 2008

Version of attached file:

Other

Peer-review status of attached file:

Not peer-reviewed

Citation for published item:

Blackman, T. and Jennings-Peel, H. (2007) 'The Whitehaven and Workington Neighbourhood Management Initiative Areas : a health impact assessment of housing, worklessness, children's services and primary care services.', Technical Report. Durham School of Applied Social Sciences, Durham.

Further information on publisher's website:

Publisher's copyright statement:

Additional information:

Use policy

The full-text may be used and/or reproduced, and given to third parties in any format or medium, without prior permission or charge, for personal research or study, educational, or not-for-profit purposes provided that:

- a full bibliographic reference is made to the original source
- a [link](#) is made to the metadata record in DRO
- the full-text is not changed in any way

The full-text must not be sold in any format or medium without the formal permission of the copyright holders.

Please consult the [full DRO policy](#) for further details.

The Whitehaven and Workington Neighbourhood Management Initiative Areas

A Health Impact Assessment

*of housing, worklessness, children's services
and primary care services*



Tim Blackman and Helen Jennings-Peel

School of Applied Social Sciences, Durham University

July 2007

Contact point: tim.blackman@durham.ac.uk

Contents

	Page
Acknowledgements	2
Summary of findings	3
Summary of recommendations	6
1. Background and context	8
2. Health of the local population	11
3. Housing and health	14
4. Worklessness and health	19
5. Primary care and health	21
6. Children's services	24
7. Discussion and recommendations	28
Appendix 1: List of documents consulted	35
Appendix 2: List of people interviewed	37
Appendix 3: Interview schedule for service providers	38
Appendix 4: Housing and health risk assessments	41
Appendix 5: Incapacity Benefit/Severe Disablement Allowance Claimants	43

Acknowledgements

The authors would like to thank the many people who have helped with this report by giving their time in interviews or by offering advice and providing documentation. In particular, we would like to thank the project's advisory group:

- Nicola Brooker, Policy & Information Officer, West Cumbria Strategic Co-ordination Unit
- Catherine Burkes, Adviser Services Manager, Jobcentre Plus, Workington
- Barbara Cannon, Chair of NMIA Board and Councillor for Moss Bay, Workington
- John Cass, Community Regeneration Manager, Copeland Homes, Whitehaven
- Kate Dixon, Co-ordinator, Cumbria Stop Smoking Service
- Mark Fryer, Neighbourhood Manager for South Workington
- Steve Hill, Performance Monitoring Officer, West Cumbria Strategic Co-ordination Unit
- Jenni Payne, Assistant Director of Public Health (North) Cumbria PCT
- Robert Porter, Director Derwent and Solway, Workington
- Nadim Quershi, Interim Neighbourhood Manager for South Whitehaven
- Emma Smith, Senior Clinical Manager, Workington, Cumbria PCT
- Mike Tichford, Head of Regeneration, Copeland Borough Council
- Ruth Willis, West Cumbria Strategic Partnership Director of Public Service Delivery and manager of the NM projects

Summary of findings

'If you improve where somebody lives, you improve how they feel about themselves, if you improve that, you improve their health, it has a knock-on effect'. Local resident.

1. The Workington and Whitehaven Neighbourhood Management Initiatives jointly commissioned this Rapid Health Impact Assessment from Durham University to assess the health impact in these areas of primary care services, housing, worklessness and children's services, and to make recommendations.
2. Both the NMIA's have high levels of deprivation, although its severity is somewhat greater in South Workington, while housing and environmental problems are greater in South Whitehaven. Deprivation is concentrated in large, mostly peripheral social housing estates. Employment is dominated by routine and manual work, and there are high levels of worklessness.
3. In 2006, almost half of adult residents in both areas reported their health as 'not good' compared to around a third in Cumbria as a whole. The ONS¹ comparative index of illness and disability for all of the twelve Super Output Areas that make up the two NMIA's is well above what would be expected given the age and sex distribution of these areas. There is also evidence of a widening health gap with the rest of Cumbria. Primary care data shows the most common health problems to be hypertension, coronary heart disease, diabetes and asthma. Mental health and sexual health issues and alcohol and drug misuse were also reported in interviews as particular problems.
4. Estimated life expectancy across the NMIA wards ranges from 71.8 to 77.3 years, well below Cumbria and national averages. The main causes of premature mortality are circulatory diseases, cancers and respiratory diseases. Patterns of mortality from these causes vary across the wards. Smoking, poor diet and insufficient exercise explain some of these health problems, but the underlying causes are the damage to health caused by past industrial employment, current worklessness and low pay, and concentrated deprivation. There is likely to be little improvement until the economic fundamentals are right, so economic regeneration of the area to strengthen the demand for labour, together with supply side educational and skills programmes, are vital.
5. Improving the liveability of the areas is an essential complement to economic regeneration. A high proportion of social housing in both areas does not currently meet the decent homes standard, and this is especially the case in the Whitehaven NMIA. Work is underway to tackle the problem, including housing market renewal. Housing conditions, and especially cold and damp, may be linked to the high asthma prevalence. Heating improvements and insulation, and a neighbourhood environment that is attractive for walking and offers good access to services and amenities, are especially relevant to improving health in the two areas. Housing renewal, however, needs to avoid unnecessary disruption, delay and uncertainty.

¹ Office of National Statistics.

6. A higher employment rate is probably the single most important way of improving population health in the two areas. Much of the worklessness is health-related. There are about 1,000 Incapacity Benefit/Severe Disablement Allowance claimants in the Workington NMIA and 1,500 in the Whitehaven NMIA. There has been little change in these totals in recent years but more are long-term and more are related to mental health problems. Recent initiatives to help people back into work, often with support for their health problems, have targeted new claims rather than long-term claimants. This is an issue in terms of the health consequences of continuing exclusion from employment for long-term claimants. Routes to Work, which started in April 2007, is targeting the most deprived wards across Cumbria to support people back to work, and this offers the potential to reach long-term claimants.

7. The impact of primary care services on health is immense; 90% of all NHS care is solely undertaken in primary care. This impact is more on severity (including death) than incidence. GP patients in both NMIA's are spread across several practices all based in the town centres. There are problems with accessing GP surgeries due to distance and limited bus services. Although the quality of primary care in both areas appears to be good, there is little proactive work being undertaken either to find people in the community with risk factors and who need treatment, or to provide ongoing support to people attempting to improve health-related behaviours, such as community-based health trainers. The CAB used to base advisors in doctors surgeries but this was withdrawn due to lack of funding and only one practice in South Whitehaven has commissioned this service. There has so far been no provision of employment advisors in GP practices. There appears to be a willingness among local employers to support people to stay in work or back to work, which could be encouraged further, including raising awareness among GPs.

8. Smoking cessation services in West Cumbria have been under-resourced for some time but the situation is now improving with new appointments. A recent health equity audit of smoking cessation services demonstrated that areas of higher deprivation were seeing less success with achieving cessation, so it is important that the extra workers target these areas, which clearly include South Whitehaven and South Workington. Clinics need to be provided at a variety of locations, including GP practices and community centres. Jobcentre Plus personal advisors offer an opportunity to deliver brief interventions among a group with high smoking prevalence. This and some other initiatives are currently under development utilising NLDC funding but it will be important to mainstream these approaches as far as possible, and to monitor and evaluate implementation.

9. Less than half of residents in the Workington NMIA in 2003 regarded the area to be a good place to bring up children. In Whitehaven, this was also the case in the Sandwith and Mirehouse wards but not so much in the other wards. Interviewees described problems with children not eating properly, abusing alcohol and drugs, not sleeping and parents not always being about. Teenage alcohol misuse was singled out as a significant problem and more so than drugs, with associated problems of criminal damage and anti-social behaviour. The proportion of 16-18 year olds not in education, employment or training is high at around 11-15% compared with 8.4% nationally. Teenage pregnancies are high, indicating underlying problems with child well-being, and many children in the two areas live in workless households. There appear to be

some issues with access to sexual health clinics, either because not all schools provide access or there is not easy access to a local clinic.

10. Educational achievement is low and there are high proportions of pupils with special needs. Most schools engage well with the Healthy Schools initiative. The Local Delivery Platform brings together people from various agencies in South Workington, including the police, health services, children's centres and Connexions. There are plans to do the same in Whitehaven, although this is likely to be harder logistically because the area is larger. The children's centres have a vital role to play in terms of early years support, providing group activities and individual support for families, often health-focused. The Whitehaven centre has a proactive programme of visits to new parents, while families are either referred or self-refer to the Workington centre. More appears to be necessary for supporting teenagers, however, including recreational opportunities that offer an alternative to alcohol and getting into trouble, help with mental health issues, and good schooling with the prospect of further education and employment.

11. There appear to be no particular issues with children accessing GPs but a substantial number of children are believed not to be registered with dentists. Child and adolescent mental health services (CAMHS) were reported to us as not meeting current needs and as being very stretched, with long waits.

.

Summary of recommendations

1. Economic regeneration should be at the heart of health improvement strategies for the two areas. The main elements of this approach should be both job creation locally and improving access to employment in the travel-to-work area; engagement with employers to promote health and increase skill levels; and engagement with local residents to increase skill levels and support people into work and with staying in employment. It should include:

- 1.1 A particular focus among regeneration, employment and skills agencies on young people and their future in West Cumbria, with an intermediate labour market programme targeting those most at risk of economic exclusion.
- 1.2 A campaign of mainstreaming healthy practices among employers and retailers, combined with social marketing to influence consumer behaviour.

2. More resources need to be targeted to the two areas to prevent a growing gap in health outcomes compared to the rest of Cumbria. This should include:

- 2.1 Developing practice based commissioning to include active case finding based on local analysis and quick and easy access to primary care services for diagnosis, treatment and referral.
- 2.2 Consultation with primary care organisations and the use of advisors, performance management and incentives to increase statins prescribing, smoking screening and brief interventions, alcohol screening and brief interventions, and risk-based screening of over-50s.
- 2.3 Welfare benefits advice services provided as standard within primary care services.
- 2.4 Employment advisors working in partnership with primary care services.
- 2.5 Delivery of smoking cessation brief interventions routinely through primary care services, Jobcentre Plus advisors and in community settings.

3. Improvements to the living environment should be aimed at improving health and encouraging people to move into and stay in the area. This should include:

- 3.1 Adopting a 'decent neighbourhood standard' that incorporates walkability (pleasant routes, clean streets, safe environments), access to healthy food (either local shops recognised for their affordable healthy food range or good public transport links to shops offering the same), healthy primary schools, and better integration of local access to public and advice services.
- 3.2 The provision of a resource pack for residents whose homes are brought up to the decency standard, containing advice about healthy cooking and family eating, quitting smoking and smoke-free homes, walking and exercise, and keeping warm.

3.3 Special measures to accompany housing market renewal that involve hard-to-reach groups such as older people to help avoid anxiety and stress. Improvement works need to be well-managed with an explicit and publicised commitment to minimise disruption for residents.

3.4 A Smoke Free Homes Campaign aimed at encouraging residents to ban smoking in their homes so as to protect non-smokers from secondhand smoke (especially children) and encourage cessation among those who do smoke.

3.5 Prioritising heating improvements and insulation in all tenures.

The Whitehaven and Workington Neighbourhood Management Initiative Areas: Health Impact Assessment

1 Background and context

1.1 The Workington and Whitehaven Neighbourhood Management Initiatives jointly commissioned this study from the School of Applied Social Sciences at Durham University. It has two aims:

- (a) To assess the impact of current policies and programmes on the health of local residents;
- (b) To make recommendations to enhance future positive health impacts and minimise negative ones.

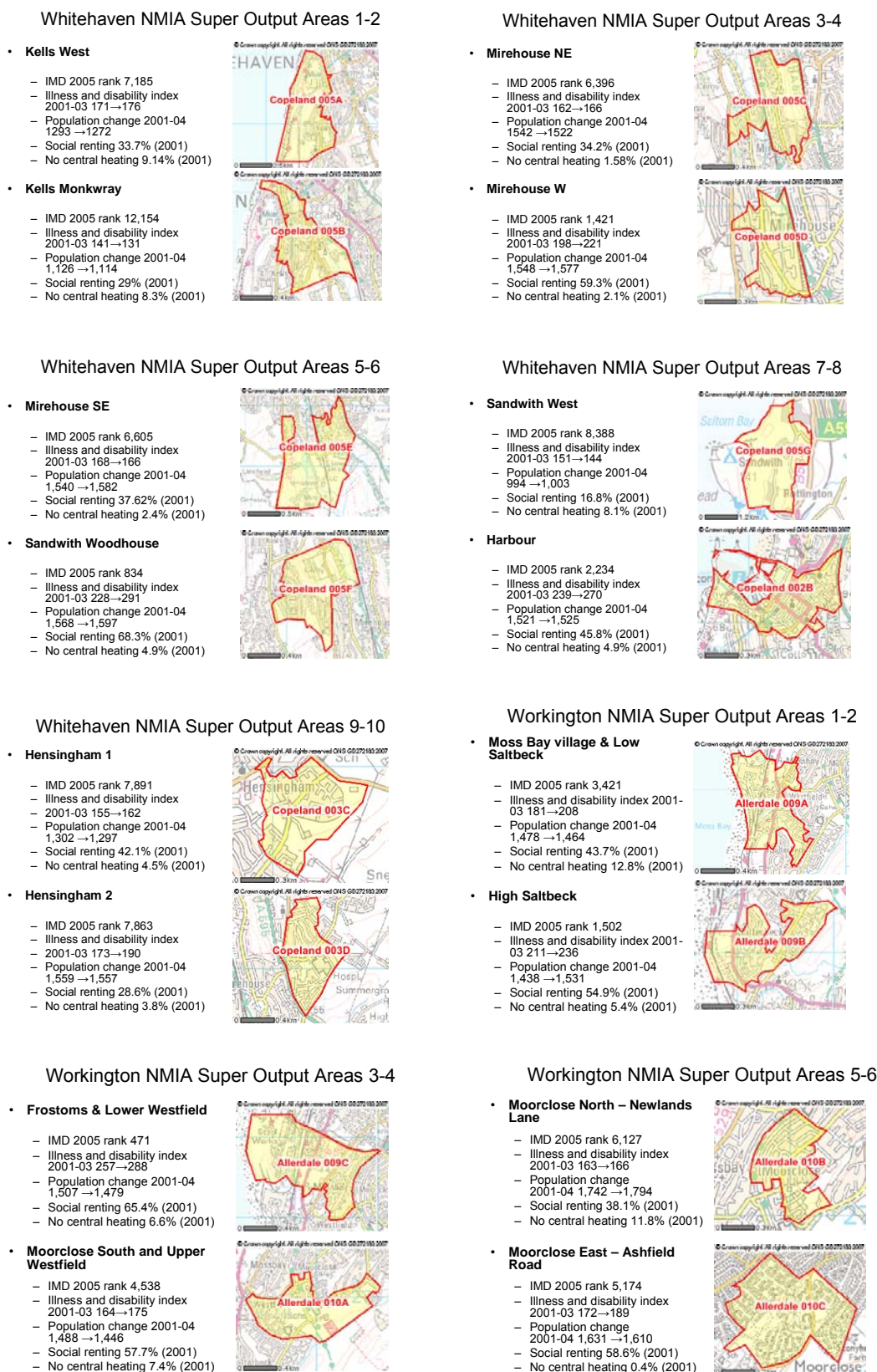
The method used is that of a Rapid Health Impact Assessment (HIA). This was conducted over three months and focused on four areas: primary care services, housing, worklessness and children's services. This method is primarily based on interviews with key informants and inspection of a range of documents and statistics. Examples of good practice have been obtained from searching bibliographies and web sites. A multi-agency steering group met in February to agree the method, in April to consider an initial draft and in July to consider the final report.

1.2 The Whitehaven and Workington Neighbourhood Management Initiative Areas (NMIAs) are deprived neighbourhoods with common problems but are not homogeneous. The Whitehaven NMIA has a population of about 14,000 people. There are particular concentrations of deprivation in the social housing estates of Greenbank, Woodhouse and Mirehouse West, and the area presents particular housing and environmental challenges. The Workington NMIA is smaller, with a population of about 9,300. Its overall levels of social housing and deprivation are higher than Whitehaven, and this appears to be reflected in some problems being more acute, such as drug and alcohol misuse and teenage conceptions. There is a particular concentration of deprivation in the Westfield/Frostoms area. The areas of concentrated deprivation in both Whitehaven and Workington are included in housing market renewal programmes. Figure 1 shows the Super Output Areas (SOAs) that comprise the two NMIAs, together with some key data about them, and is commented on further below.

1.3 Many residents in the two areas are workless. Employment in mining and chemical industries has been lost, with only partial replacement of these jobs in retailing and services, which often pay less well. Sellafield is a major local employer but losses of a large number of well paid jobs may occur as a result of decommissioning². Much of the worklessness is now health-related or associated with single parenting.

² *Strategy for Sustainable Communities in West Cumbria 2007-2020 Draft for Discussion*, February 2007.

Figure 1. Profiles of the NMIA Super Output Areas



1.4 Although a majority of residents are satisfied with the local area, most parts are not popular places in which to live and there is little population growth. Demand is largely from families brought up locally who identify with very local communities. The age structure of all the wards is similar to the national average except for the Sandwith ward, which has more children, and Harbour ward, which has more older people³.

1.5 The two wards of the Workington NMIA, Moss Bay and Moorclose, have more than 60% of those in employment working in routine or manual occupations⁴. The Sandwith and Mirehouse wards in Whitehaven have similar economic profiles to the Workington wards, while the other three wards are not quite so deprived and have higher proportions of private housing. For the working age population in these areas, routine and manual employment and worklessness are major risk factors for circulatory diseases, cancers and respiratory ill-health. Nationally, these risks are also associated with living in social rented housing but this is likely to reflect an underlying relationship with housing and neighbourhood problems rather than the tenure as such. In general, people facing these risks are more vulnerable to dangerous illnesses, are less likely to have their symptoms identified and are less likely to be receiving treatment. Children are especially vulnerable to growing up in these circumstances, with health effects often continuing into adulthood. Local rates of teenage pregnancies are high, which is itself a marker of problems with child well-being⁵.

1.6 The high incidence of low pay in West Cumbria reflects a relatively low level of skills among the workforce. According to the 2001 census, around 50% of unemployed people in the two areas had no qualifications. This was also the case for between 25% and 45% of the employed population across the seven wards. Problems with basic skills such as reading and writing were often mentioned to us in interviews. Improving skills is likely to be as important to the health agenda as to the economic agenda. Although there are relatively few businesses creating a demand for skills, there are some that told us they had found it difficult to recruit people with ICT expertise and construction skills. There is some evidence, however, that the level of skills is improving. The 2006 Cumbria Quality of Life Survey records the proportion of unemployed respondents in the Whitehaven NMIA without any formal qualifications as 39% and of employed respondents without any formal qualifications as 15%. For Workington the figures are 43% and 20%⁶. The sample size of the 2006 survey means that there is a margin of error of about +/- 5% with these figures, but they still suggest some improvement in skill levels.

1.7 Part of the health impact of worklessness and manual or routine employment operates through an effect on lifestyles, especially smoking and diet. Intervening in an attempt to change these behaviours will not have a significant effect if the underlying economic deprivation persists. Equally, however, supporting someone back into employment may not deliver its full potential health benefit if there is not the support available to help with changing behaviour, such as quitting smoking.

³ 2001 Census.

⁴ 2001 Census.

⁵ Multi-national Project for Monitoring and Measuring Children's Well-Being <<http://multinational-indicators.chapinhall.org/>>.

⁶ Cumbria Quality of Life Survey 2006.

1.8 Improving the economic circumstances of individuals will also not improve health in the two areas if people then choose to leave. People with jobs need reasons to stay living in the two NMIA's. Attending to the choice of housing, the liveability of the local environment and the quality of schools are key to this.

1.9 The concern most often mentioned in both areas by adult respondents in the 2006 Quality of Life survey was the lack of activities for teenagers, closely followed by poor job prospects⁷. A lack of facilities for young children was also often mentioned as a problem. In terms of both prevalence and importance, however, the dominant concern in both areas was crime. One-fifth of residents had been a victim of crime in the past year and over two-thirds were worried about being a victim of crime. Many residents reported as serious problems people using or dealing drugs and parents not taking responsibility for their children's behaviour.

1.10 Almost half of adult residents in both the areas felt they had no influence over decisions affecting their area. About a third in both areas wanted more say. Levels of trust were also low. A quarter of adult residents in the Workington NMIA and a fifth in Whitehaven did not trust their neighbours.

1.11 These problems are well-known among service providers and progress has been made with schemes to divert young people from anti-social and risky health-related behaviours and improve community safety. Consultation with residents is also more common now than in the past.

2 Health of the local population

2.1 Almost half of adult residents (aged 16 plus) in both areas reported their health as 'not good' in 2006⁸. This compares to around a third in Cumbria as a whole. Over a third of residents in both areas have a long-term health problem or disability. Self-reported depression ranges from 18% to 28% across the wards⁹. Levels of sedentary lifestyles, poor diet and hospitalisation are higher than average.

2.2 Figure 1 shows the ONS comparative index of illness and disability for the SOAs in the two areas, with data for 2001 and 2003¹⁰. An index of 100 is what would be expected given the SOA's age and sex distribution. All the 2003 values are well above what would be expected, reflecting the extent of deprivation. The Frostoms/Lower Westfield SOA in Workington has the highest index of any of the sixteen SOAs. In Whitehaven, the index is particularly high in the Sandwith Woodhouse and Harbour SOAs.

2.3 Primary care (QOF) data from GP practices in the two areas shows the most common health problems to be hypertension, coronary heart disease, diabetes and

⁷ Cumbria Quality of Life Survey 2006.

⁸ Cumbria Quality of Life Survey 2006.

⁹ North Cumbria Health and Lifestyle Survey 2003.

¹⁰ This is based on the indicator used in the generation of the Indices of Deprivation 2004. It is a standardised measure of illness and disability.

asthma¹¹. Not so apparent from the QOF data are mental health and sexual health problems, which were identified as common in our interviews with primary care practices. Family support workers also cited as 'above average' postnatal mental health problems, young male suicide and drug and alcohol misuse.

2.4 Smoking prevalence is high: 33% of respondents in the 2006 Quality of Life survey in Workington and 28% in Whitehaven stated that they currently smoked cigarettes, compared to a Cumbria average of 19%¹². Across all the NMIA wards, the 2003 Health and Lifestyle Survey reports adults eating less than three pieces of fruit and vegetables daily as ranging from 42% to 56%, the proportion not taking recommended levels of exercise as ranging from 56% to 72%, and rates of obesity as ranging from 16% to 25%¹³. High alcohol consumption was less prevalent than in Cumbria as a whole¹⁴. These figures are sample estimates but they indicate a population issue regarding these risk factors rather than a problem of individual behaviour. The above-average levels of smoking, poor diet and low physical activity are likely to have causes that are affecting significant numbers of people in a similar way.

2.5 As might be expected from the prevalence of these risks, premature mortality is above average in the two NMIA, although lifestyles factors will only explain part of the lower life expectancy in these areas¹⁵. In South Workington, life expectancy in Moorclose is estimated as 77.3 years and in Moss Bay 71.8 years (data for 1999-2003)¹⁶. In Whitehaven, life expectancy is estimated as 73.2 years in Mirehouse, 75.2 years in Sandwith, 73.1 years in Harbour, 75.8 years in Kells and 77.2 years in Hensingham. These figures compare with the best wards in Allerdale and Copeland: 84.2 years and 82.5 years respectively. The best ward in Cumbria has a life expectancy of 91.3 years.

2.6 Table 1 ranks the NMIA wards on estimated life expectancy and compares this with the proportion of the population in each ward with no car or van¹⁷. The latter is widely used as a measure of low income but is also likely to have a direct effect on access to health care. In general, although the confidence intervals overlap the trend in life expectancy tends to mirror differences between the wards in vehicle ownership (a rank correlation of 0.76). Across all the wards both life expectancy and vehicle ownership are low compared to Cumbria and national averages.

¹¹ QOF Database 2006 <<http://www.gpcontract.co.uk/search.php?year=6>>.

¹² Cumbria Quality of Life Survey 2006.

¹³ North Cumbria Health and Lifestyle Survey, 2003

¹⁴ Although there is a positive correlation between deprivation in North Cumbria and hospital admissions for alcohol specific conditions (Clay, 2006; see also Morleo et al., 2006). Binge drinking and vulnerability to physiological damage from alcohol due to other accumulated risk factors may mean a greater impact on health despite apparently lower than average self-reported alcohol consumption.

¹⁵ Marmot, M. and Wilkinson, R. G. (eds) (1999) *Social Determinants of Health*, Oxford: Oxford University Press.

¹⁶ <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=14466>

¹⁷ 2001 census.

Table 1: Life expectancy, no qualifications and vehicle ownership by ward

	Life expectancy (confidence interval)	Rank	No car or van	Rank
Moss Bay	71.8 (69.9-73.8)	7	49%	7
Harbour	73.1 (71.0-75.3)	6	44%	5
Mirehouse	73.2 (71.3-75.0)	5	43%	4
Sandwith	75.2 (73.0-77.4)	4	45%	6
Kells	75.8 (73.0-78.7)	3	33%	1
Hensingham	77.2 (75.2-79.2)	2	34%	2
Moorclose	77.3 (75.9-78.7)	1	39%	3

2.7 Nationally, the main contributors to inequalities in life expectancy are circulatory diseases, cancers and respiratory diseases. Patterns of mortality from these causes vary across the wards. For circulatory diseases, death rates are particularly high in Sandwith (an SMR of 188, or 88% above the national average), Mirehouse (an SMR of 161, or 61% above the national average) and Harbour (an SMR of 134, or 34% above the national average)¹⁸. For cancers, death rates are particularly high in Kells (an SMR of 152, or 52% above the national average) and Moss Bay (an SMR of 144, or 44% above the national average). Neither Hensingham nor Moorclose figure in these high death rates, which reflects their relatively more favourable position with regard to life expectancy (table 1). Given its particularly low life expectancy, Moss Bay might be expected to have higher death rates from circulatory diseases and cancers. This ward does, however, have a relatively high rate of limiting long-term illness and disability, 27% compared to an average across the wards of 24%¹⁹, and a very high proportion of its working age population is in receipt of Incapacity Benefit or Severe Disablement Allowance, 23% compared to a ward average of 16%²⁰.

2.8 The need for more resources was often mentioned in interviews. There is a common perception that West Cumbria does not receive a level of resources that sufficiently recognises its needs compared to other parts of Cumbria, and that this is compounded by not having Spearhead designation. If this continues, there is likely to be a *widening* of the gap between the health of people living in the two NMIA's and the rest of Cumbria. To illustrate this, figure 2 uses the ONS comparative illness and disability index to measure the gap between each SOA in the two NMIA's and the Cumbria average, for 2001 and in 2003. The graphs show that the gap has widened in almost all the SOAs, with a marked pattern of the gap widening most in the SOAs with the worst health.

2.9 In summary, the health problems of the two areas reflect their high levels of deprivation, but there are differences in both the extent of deprivation and the distribution of particular causes of premature mortality. Half of adult residents rate their health as 'not good' and teenage pregnancies are high, reflecting underlying problems with child well-being. Health-damaging behaviours are significantly more common than in the general population. Deaths from circulatory diseases and cancers

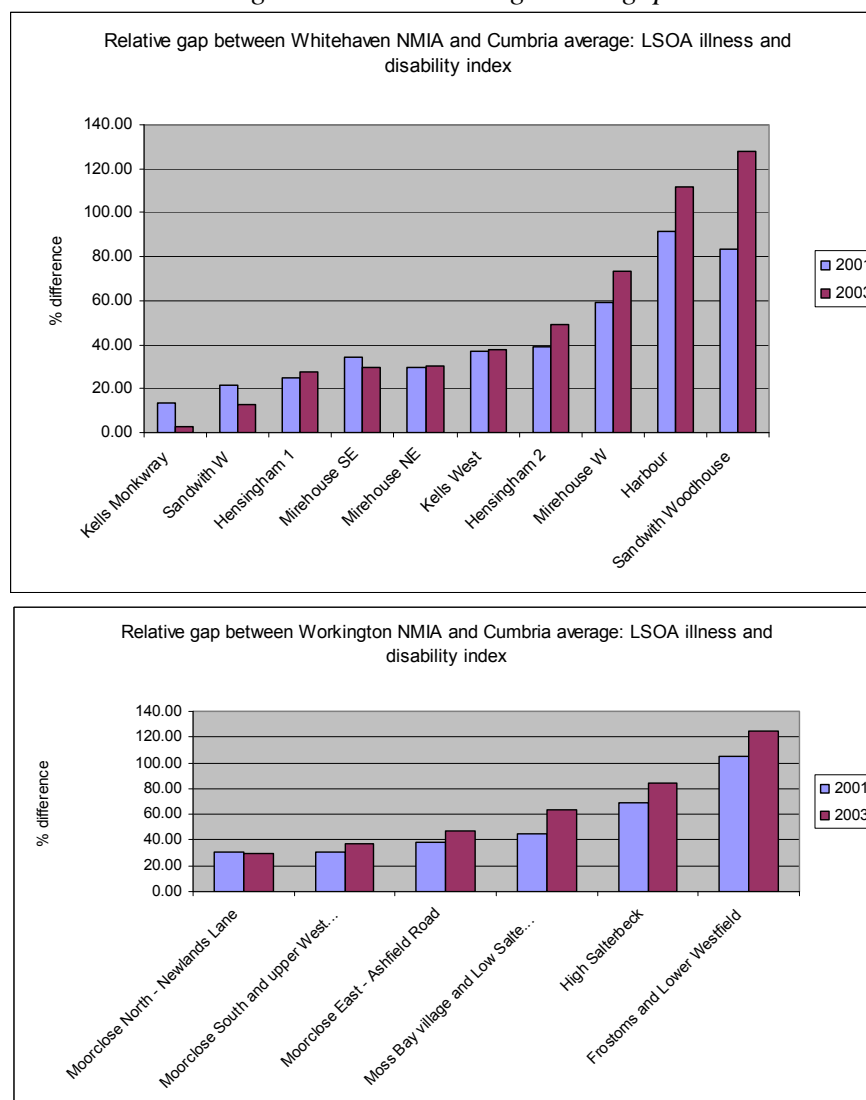
¹⁸ Data for 1998-2002.

¹⁹ 2001 census.

²⁰ DWP data for 2002 to compare with 1999-2003 life expectancy estimates, using 2001 census data for working age population.

are well above average. However, much of this morbidity and mortality is preventable and much will be treatable. A key issue is whether the right things are being done, in the right way, to prevent and treat as many of these health problems as possible.

Figure 2: The widening health gap



3 Housing and health

3.1 The high proportion of social housing in the two areas concentrates deprivation in relatively large housing estates. People with longstanding illnesses or disability are also more likely to need social housing because they cannot access owner-occupation. Although there is debate about the evidence, on balance the research points to the spatial sorting of poor households into neighbourhoods with many other poor households as having a damaging effect on community health over and above individual factors²¹. Mixed income communities are likely to deliver health benefits for all residents. Beyond these socioeconomic effects, social housing estates may also expose residents to health-damaging housing problems such as damp and

²¹ Blackman, T. (2006) *Placing Health*, Bristol: Policy Press.

cold because of poor construction or inadequate maintenance, and to health-damaging neighbourhood effects such as poorly maintained public spaces that discourage walking and may depress mental health; a lack of pleasant green spaces with trees (and a tendency for any green spaces to be large expanses of grass) that similarly discourage outdoor activity and mixing with neighbours; concerns about personal safety or abuse; and a lack of decent shops and other amenities, compounded by low levels of car ownership and infrequent bus services. This is by no means always the case with social housing, and conditions range from popular, pleasant estates to areas blighted by low demand and boarded up houses. Figure 3 shows the range of conditions that can be found in South Whitehaven, where the environment on its social housing estates is generally poorer than in South Workington.

3.2 A high proportion of social housing in both areas does not currently meet the decent homes standard, and this is especially the case in the Whitehaven NMIA. Derwent & Solway's decency rate in Workington was reported as 70% in April 2006 and Copeland Homes' rate in Whitehaven as 48.2%²². Derwent & Solway is likely to meet the 2010 target of a 100% decency rate but Copeland Homes is unlikely to meet the target until 2012. Housing conditions, and especially damp, were identified in one of our primary care interviews as linked to high asthma prevalence. Work to meet the decent homes standard for social housing is being delayed by housing market renewal plans. Not all financial and capacity issues have been resolved for what is likely to be a programme of redevelopment lasting up to 10 years.

3.3 Rates of owner-occupation in both areas are low by Cumbria and national standards, although just over half of households in both areas are owner-occupiers. Private ownership brings stability to neighbourhoods but in such a low income area there is a risk that some households will not be able to afford to keep their homes maintained or may get into difficulty with mortgage payments. Data from the 2001 census shows that the SOAs with more private housing are also more likely to have a higher proportion without central heating (see Figure 1). It will be particularly important to ensure that vulnerable owner-occupiers and private tenants are receiving help with heating improvements and insulation.

3.4 We asked representatives from the local councils and the main registered social landlords to complete an assessment of the various housing-related risks to health, together with an assessment of practice for each risk. The results are presented in Appendix 4. Each risk is shown in a category relating to the health problem associated with it. Both the risk and the associated policy and practice are scored out of 5. '0' is 'don't know'. The higher the risk score, the greater the risk; the lower the practice score, the more that practice needs to be developed. Risks are presented by the solid black bars and policy and practice by the striped bars. The key risks are where the risk is assessed as 4 or 5 (fairly or very common) *and* practice is assessed as 1 or 2 (needs a lot of or some development).

3.5 In South Workington, assessments were completed by representatives of Derwent & Solway and Allerdale Council. Key risks were assessed as speeding, anti-social behaviour, concentrated social deprivation, neighbourhood problems, arrears,

²² West Cumbria Strategic Partnership *Public Services in West Cumbria – Annual Review 2005-6*. April 2006 version.

cold homes, damp and condensation, lack of partnership working, and a neglect of the effect of policies and practices on health. Areas where risk was assessed as high and practice as also needing development were concentrated social deprivation, cold and damp homes, partnership working, and the effects of policies and practices on health.

Figure 3: Social housing areas in Whitehaven



3.6 In South Whitehaven, an assessment was completed by a representative from Copeland Homes. More risks than in South Workington were assessed as common. The key risks were identified as antisocial behaviour, crime, environmental problems, problems with consultation, neighbourhood problems, concentrated social deprivation, arrears, homelessness, cold homes and mobility problems in the home. Areas where risk was assessed as high and practice as also needing development were anti-social behaviour, environmental problems, consultation, concentrated social deprivation, homelessness, mobility problems in the home, and accessing healthy food.

3.7 Teenage homelessness was singled out as a problem by some people we talked to. This mainly takes the form of young people sleeping on someone's sofa or feeling they will shortly have to leave home rather than rough sleeping as such. A new multi-agency partnership is being set up in West Cumbria to address the problem by identifying vulnerable children and those at risk, and providing support.

3.8 About a third of residents in both areas in 2006 reported dissatisfaction with the availability of suitable housing²³. There is a mismatch between housing need and the type of stock available. Need is shifting to smaller households (often older people needing bungalows) and teenage households and people with drug or alcohol problems needing support. The social housing stock, in contrast, has a preponderance of larger conventional 3-bedroom houses.

3.9 Housing market renewal is expected to help re-balance the housing stock but also has an important wider purpose to change the tenure structure. It should attract home buyers into the areas to help mix estates, encourage residents to invest in their homes, and keep local services viable. This is an opportunity to create mixed tenure neighbourhoods in areas where the dominant tenure is currently social renting. There is some evidence that communities which include at least some middle-income households have a better overall health profile for both adults and children than entirely low-income communities²⁴. There is also established good practice for creating mixed-income neighbourhoods, including providing a full range of house sizes and types, ensuring a high quality external environment, enabling households to move house within the development, and attracting newcomers²⁵. It is important, however, that housing renewal is carried out in a way that minimises any blight, disruption and uncertainty for local residents. These problems can damage the health of communities affected by housing renewal²⁶.

3.10 Housing conditions that affect health include cold, damp and hazards such as unsafe stairs²⁷. But the neighbourhood environment is also very important: its perceived safety, and how clean, green and looked after it is. Improving the physical condition and look of the neighbourhood is likely to deliver health benefits, including

²³ Cumbria Quality of Life Survey 2006.

²⁴ Blackman, T. (2006) *Placing Health*, Bristol: Policy Press.

²⁵ Bailey, N. *et al.* (2006) *Creating and sustaining mixed income communities*, York: Joseph Rowntree Foundation. <<http://www.jrf.org.uk/bookshop/eBooks/9781905018314.pdf>>

²⁶ Liverpool City Council *et al.* (2004) *Health Impact Assessment of Liverpool City Council's Housing Strategy Statement: Final Report 2003*, Liverpool: Liverpool City Council.

²⁷ Battersby, S. *et al.* (2002) *Statistical Evidence to Support the Housing Health and Safety Rating System*, Vols 1-3, London: ODPM.

trees and greenery planted in consultation with residents (and avoiding large, anonymous grassy areas)²⁸. The importance of trees and greenery to encouraging physical activity, mixing with neighbours and mental well-being should not be underestimated. People are more likely to walk if the environment is clean and green, and without evidence of behaviours such as drug misuse.

3.11 In the 2006 Quality of Life survey, residents reported a better local environment in Workington than in Whitehaven. Many residents in the Whitehaven NMIA had concerns about the state of roads, pavements and street litter²⁹, although other data suggests the main problems were in Sandwith and Mirehouse rather than the other three wards³⁰. The situation should be improving as the frequency of street cleaning has been increased substantially in an effort to close the gap in street cleanliness with the Cumbria average. Many residential roads, however, are in a poor state. A new play space has also been opened in Mirehouse, with CCTV, and lighting improved. These improvements to cleaning and public spaces are very dependent on short-term funding.

3.12 Social housing landlords have an important role to play working with other agencies to improve opportunities for their tenants, and are already doing so in Workington and Whitehaven. Copeland Homes works with the volunteering agency Young Cumbria, Connexions and local youth clubs; it supports sport initiatives to engage young people in school and healthier lifestyles, greening projects and training and employment schemes, and encourages its tenants to join the local credit union. They have a dedicated Community Development Team and a 10-year £1.25m Community Fund that prioritises activities for children and young people and crime prevention³¹. Similarly, Derwent & Solway have a strong emphasis on partnership working that includes supporting people back into work, money advice and working with credit unions, community greens and working to improve bus services. It is developing Project ASIA that will provide a web portal to improve access to advice and information, including providing web access in community venues. Joint working with the Healthy Communities Group is also in development.

3.13 In summary, Workington and Whitehaven's social housing estates concentrate deprivation and health problems, making it important that health and other services reach into these communities. There are particular problems with the quality of the environment and housing in South Whitehaven and slower progress with meeting the decent homes standard. Much work is either underway or planned to bring the stock up to the decency standard as well as to diversify tenure in these neighbourhoods. These measures are likely to improve health but need to be managed in a way that minimises disruption, blight and uncertainty for residents. There is also an opportunity to implement them in ways that are informed by evidence about health improvement. Heating improvements and insulation, and a neighbourhood environment that is attractive for walking and offers good access to services and amenities, are especially relevant in this respect.

²⁸ Blackman, T. (2006) *Placing Health*, Bristol: Policy Press.

²⁹ Cumbria Quality of Life Survey 2006.

³⁰ North Cumbria Health and Lifestyle Survey 2003.

³¹ <http://www.copelandhomes.com/index.php>

4 Worklessness and health

4.1 A higher employment rate is probably the single most important way of improving population health in the two areas. Employment is likely to improve mental health and encourage a healthier lifestyle, especially cutting down smoking or quitting altogether. It is clear, however, that many people need support to access jobs, with a lack of confidence about employment and entrenched benefit dependency reflecting many years of a lack of strong local demand for labour. These labour market conditions also mean that employers may be more selective about who they hire. There is some national evidence that people with physical disabilities and especially people with mental health problems are less likely to be recruited by employers than lone parents or long-term unemployed people³².

4.2 There are about 1,000 IB/SDA claimants in the Workington NMIA and 1,500 in Whitehaven (see table 2 and appendix 5). Moss Bay and Sandwith have the highest proportions of their working age populations claiming these benefits, and Kells and Hensingham the lowest. There has been little change in these totals in recent years but the composition of claims has been changing. More are long-term and more are related to mental health problems. The main age group is 25-49 years. The main health problem is mild to moderate depression, although musculoskeletal conditions may often be the initial reason for a claim.

Table 2: Incapacity Benefit/Severe Disablement Allowance

	IB/SDA claimants August 2006	Claimants as % working age population
Moss Bay	565	23%
Sandwith	325	22%
Harbour	390	17%
Moorclose	445	16%
Mirehouse	405	16%
Kells	165	12%
Hensingham	285	12%

4.3 Recent initiatives to help people back into work have targeted new claims rather than long-term claimants, and this is an issue in terms of the health consequences of continuing exclusion from employment for long-term claimants. All IB claimants are seen by a personal advisor when they make their claim and if they are still claiming after 8 weeks they receive a mandatory work-focused interview. This may result in being screened into Pathways, generally for 'harder to help' claimants, such as those without a job to go back to or a working spouse, and this involves monthly interviews for six months. The Pathways scheme offers referral to the Condition Management Programme, which provides work-focused help with managing health and disability problems. Alcohol brief interventions training has also been arranged by the PCT for the condition management team. Interviews for other claimants are voluntary but there are occasions when they are required to attend for an interview. Routes to Work, starting in April 2007, is targeting the most deprived

³² Kemp, P. A., Sunden, A. and Tauritz, B. B. (2006) *Sick Societies? Trends in disability benefits in post-industrial welfare states*, Geneva: International Social Security Association.

wards across Cumbria to support people back to work, and this offers the potential to reach long-term claimants.

4.4 There has so far been no provision of employment advisors in GP practices. It was suggested to us in interviews that there can be a lack of awareness among GPs of the support available. One Jobcentre Plus manager commented, 'We need more referrals from GPs. GPs can sometimes still be in a culture of issuing sick notes all the time. They need better understanding about what we're doing. We're not trying to replace what they do. We need to get out there and let people know what's on offer.'

4.5 Jobcentre Plus managers were also clear about the need to have more presence in local communities to encourage people to access the support available. A project in Barrow that based staff in high unemployment communities had been 'hugely successful' according to one of our interviewees, but was no longer running. It was one of the Action Teams for Jobs set up in 2004 in various parts of the country to reach into deprived neighbourhoods. The national review of this initiative drew a number of important conclusions:

'Having an outreach service, flexibility of funding, partnership working, and a voluntary programme to address worklessness in these areas were all seen as crucial features of Action Teams that needed to continue in the work of Jobcentre Plus in deprived areas. It is also important to ensure that any future programmes take on board the understanding of the extremely localised geography of worklessness, and tackle the pockets of worklessness found in a variety of labour markets including cities, seaside towns, rural areas, and ex-industrial areas.'³³

4.6 Efforts are being made currently to liaise with services and organisations working in the local community in Workington and Whitehaven so they can help raise awareness among residents about the support available and advise on how best Jobcentre Plus can deliver its services.

4.7 The Jobcentres report very good retention when people do find work. Championing of applicants by advisors appears to be important and effective. Halfway house provision is essential for many people moving off IB or long-term sick leave through part-time employment, intermediate labour market schemes or voluntary work. It was suggested to us that there is not enough information for people about these opportunities, including allaying fears about losing benefit.

4.8 We interviewed the Employment Support Project in North Copeland. There is no equivalent in Allerdale. We found that they had a substantial demand for their service supporting people back to work and could hire an additional worker. They had experienced some problems with the Jobcentre due to its staff turnover, such as inappropriate referrals. They manage to get about 27% of their cases into employment, often having to improve basic skills and address issues such as personal hygiene. They believe that links with health services could be better and saw a direct link between people's employability and tackling mental health problems and social

³³ Casebourne, J., Davis, S. and Page, R. (2006) *Review of Action Teams for Jobs*. Department for Work and Pensions Research Report No. 328. London: DWP.

skills (including self-esteem and confidence). A project had been based in their building, set up by health visitors and using SRB funding to employ a healthy communities worker, but had been withdrawn because there were not enough health visitors to help run the service. Mothers were helped with healthy eating and then asked if they had thought about going back to work once they had lost weight and started feeling better about themselves.

4.9 Our employer interviews did not suggest a significant problem with sickness absence and there was a good approach generally to occupational health. Small businesses, however, may be unsure about how to handle sickness absence due to mental health problems. There also seems to be a willingness among employers to support people to stay in work or back to work, which could be encouraged further, including raising awareness among GPs. The personnel manager of a large retail company told us that doctors sometimes did not understand the support and adjustments that could be made to help a person stay in work. Liaison between employers and practices was important. This company was planning to write to practices to raise awareness generally about adjustments that could be made. They felt that simply providing a sick note could sometimes add to the person's problems by creating financial worries if they could not work.

4.10 In summary, there are three important issues in terms of health impact. The first is preventing as many employees as possible who start receiving sickness benefit from progressing to IB, as it is much more difficult to move someone into work once they become an IB claimant. The West Cumbria Strategic Employment Group is seeking to engage employers in occupational health and preventing progression to IB dependency should be a key target. The second is the loss of contact that occurs with long-term IB claimants, many of whom could move into work or an activity that could lead to work. This is currently a gap in provision, which focuses on new claimants, and is likely to have a significant health cost associated with it. The third is to engage GPs, and probably initially practice managers, with employment services and with employers. There also appears to be a lack of support services in West Cumbria to which to refer people with mental health problems, which is likely to make helping some people both stay in employment and get back into employment more difficult.

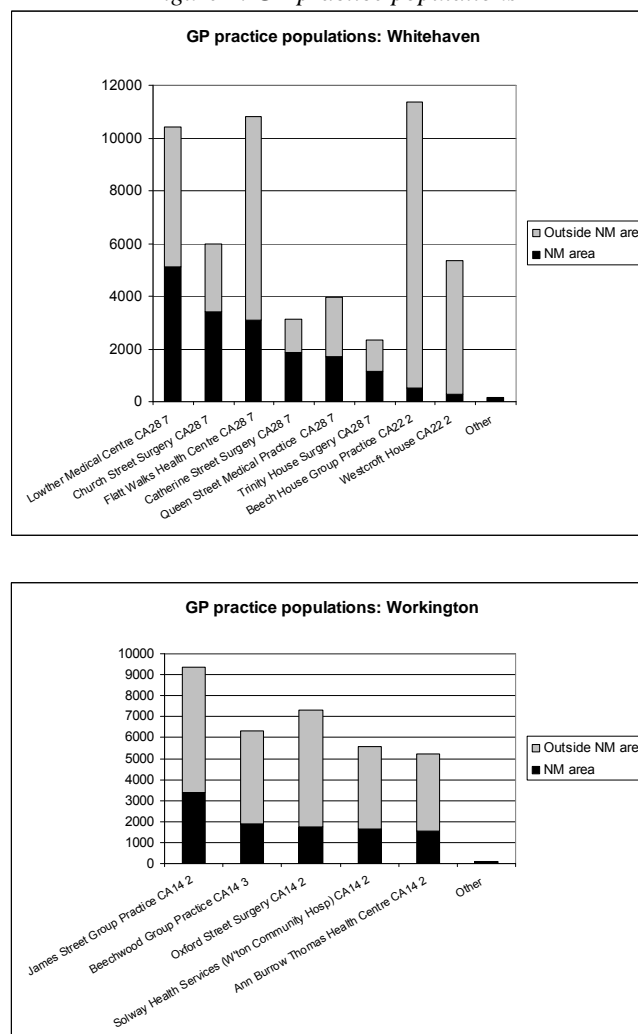
5 Primary care and health

5.1 The impact of primary care services on health is immense; 90% of all NHS care is solely undertaken in primary care. This impact is more on severity (including death) than incidence. As inequalities in the severity of health problems (including disability, death and co-morbidity) are even greater than inequalities in the incidence of health problems, primary care has a major role to play in reducing inequalities in health, such as achieving higher levels of statins prescribing in deprived areas.

5.2 The size of the GP practices that serve the residents of the two areas varies considerably, especially in Whitehaven (see figure 4). GP patients in Whitehaven are mainly spread across six practices based in the town centre (although some are registered at two Egremont practices, Beech House and Westcroft, and are travelling

some six miles to these practices). Patients in Workington are spread across five practices, also based in the town centre.

Figure 4: GP practice populations



5.3 Residents' satisfaction with GPs in both areas was high in 2006³⁴. However, a notable 18% of residents in Workington reported dissatisfaction, compared to 10% in Whitehaven. In both areas, however, by far the highest dissatisfaction with health services concerned dentists.

5.4 Problems with accessing GP surgeries and poor bus services were identified by people we interviewed in Whitehaven. Bus services have been reduced over the past ten years, although there are plans to run a circular bus service as a pilot funded from the NMIA budget. Restricted bus times also create a barrier to accessing employment. In most of the wards in both the Whitehaven and Workington NMIA's more than two out of five households had no car or van in 2001³⁵. With some homes two miles away from GP practices, which are located in the town centres, access to surgeries will not be easy unless you are relatively fit. The North Cumbria Health and Lifestyle Survey suggests that in both towns self-reported problems with accessing

³⁴ Cumbria Quality of Life Survey 2006.

³⁵ 2001 Census.

GP surgeries increase with distance from the town centres. There are also no dentists based in the areas and, until recently, no pharmacists (a new pharmacy has opened in Mirehouse in South Whitehaven).

5.5 The quality of health care services and especially primary care in both areas appears to be good. Once patients walk through the door and are on the system because of a risk factor or chronic condition, they are actively monitored. However, there is little proactive work being undertaken either to find people in the community with risk factors and who need treatment, or to provide ongoing support to people attempting to improve health-related behaviours, such as community-based health trainers. It is very likely that in such disadvantaged areas active case finding would result in more people presenting and receiving monitoring and treatment, and that this could make a significant contribution to reducing premature mortality. The PCT is awaiting NICE guidance before undertaking any further work on QOF indicators. There is currently no funding for health trainers and a decision is awaited as to whether health trainers will be adopted as a local approach. Other than some diabetes prevalence modelling by public health analysts in the PCT that has been shared with practices, no surgeries appear to use data on the estimated prevalence of diseases in the areas they serve and compare this with their registers to gauge the level of unmet need. One health professional commented to us, 'We just give them the information and tell them why we are advocating a particular strategy, then it's up to them to take our advice or not'.

5.6 There have been exercise on prescription schemes but, in terms of free local sessions, these appear to have stopped due to lack of funding (patients may still be referred but have to pay). Referral to the smoking cessation service works well from the perspective of most GP surgeries we spoke with. Other evidence, however, suggests that people from the communities with highest smoking prevalence do not feel comfortable with the service. Community-based sessions are more likely to have an impact and this is under development with some NLDC funding.

5.7 Primary care access to alcohol advisors also appears to be good but alcohol screening is not standard practice so there may be significant unmet need (screening could be promoted by a QOF indicator). Alcohol brief interventions training has been offered to all GP practices in North Cumbria and the uptake has been good. Working relationships with Social Services appear to be variable, with GPs regretting the withdrawal of social workers from surgeries.

5.8 The CAB used to base advisors in doctors surgeries but this was withdrawn due to lack of funding (it had relied on short-term HAZ funding). A practice manager commented to us that, 'we found this reduced the number of people presenting with depression and reduced the number of doctor appointments taken up with people who weren't really ill, who were just worried about being in debt or their housing situation and so on ... the regular attendees didn't seem to be so regular since they'd been to the CAB advisor.' Unfortunately, no evaluation data are available. Patients are still referred to the CAB and although the organisation has approached practices about funding to run sessions in their premises, only one practice (the Flatt Walks Clinic in South Whitehaven) has commissioned this service. The CAB do run some local sessions in community venues.

5.9 There are problems with recruitment and retention of medical staff at West Cumberland Hospital in Whitehaven which have caused problems with accessing specialists for patients. Hospital services in the area are under review and there is uncertainty about the future of the hospital.

5.10 In summary, primary care is probably not having the positive impact it could have on health inequalities because it is reactive rather than proactive in finding cases and providing treatments. This is a particular problem because of issues of accessing town centre provision for the poorest or least mobile residents. Joint working with advice agencies is underdeveloped. Some important new developments are in hand, such as brief intervention training.

6 Children's services

6.1 Less than half of residents in the Workington NMIA in 2003 regarded the area to be a good place to bring up children. In Whitehaven, this was also the case in the Sandwith and Mirehouse wards but not so much in the other wards³⁶. Interviewees described problems with children not eating properly, abusing alcohol and drugs, not sleeping and parents not always being about. Teenage alcohol misuse was singled out as a significant problem and more so than drugs, with associated problems of criminal damage and anti-social behaviour. Domestic violence was also mentioned and is reflected in crime data. The proportion of 16-18 year olds not in education, employment or training (NEETs) is high at around 11-15% (compared with 8.4% nationally)³⁷. Teenage pregnancies are high (see below) and many children in the two areas live in workless households.

6.2 We were told that schools in both of the NMIAs engage well with the Healthy Schools initiative. The four local primary schools in Workington have high levels of pupils with special educational needs (22-40%)³⁸. Although three of these schools have seen increasing numbers of their pupils achieving at level 4 and above in recent years, in two this fell back in 2006. Westfield Nursery and Primary School and Victoria Infants School were cited to us as examples of good practice with promoting healthy school meals and packed lunches.

6.3 The Workington primary schools feed to the local secondary school, Southfield Technology College. This school has had improving results in GCSEs, but achievement is low at 29% achieving five or more GCSEs at grades A*-C in 2006. Its value-added score, however, is better than both of the Whitehaven secondary schools.

6.4 Extended schools are under development in Cumbria, with the aim of providing universal 8am-6pm wrap-around care by 2010. Southfield Technology College runs before- and after-school clubs. Its head teacher told us that 'the whole ethos of the school is the health of the children'. She faces significant problems, such as drug dealers coming into the grounds, and a lack of financial resources for what she

³⁶ North Cumbria Health and Lifestyle Survey 2003.

³⁷ *Building Pride & Respect in South Whitehaven: Neighbourhood Management in South Whitehaven 2006-2010*.

³⁸ DfES school performance data <http://www.dfes.gov.uk/performance/tables/schools_06.shtml>.

feels is necessary to address these problems. Only a few schools in West Cumbria as a whole run breakfast clubs, and there is a lack of funding for this provision.

6.5 Compared to the Workington schools, the four local primary schools in Whitehaven have lower levels of pupils with special educational needs (11-34%). They have been doing better than the Workington primaries with improving their level 4 attainment, but two also saw this fall back in 2006. They feed into two local secondary schools, Whitehaven School and St Benedict's Catholic High School. Whitehaven achieved 28% GCSEs at A*-C in 2006, while the Catholic school achieved 52%. The difference in their value added scores, however, is considerably smaller (and not significant statistically).

6.6 In South Workington, the Local Delivery Platform brings together people from various agencies, including the police, health services, children's centres and Connexions. This facilitates a multi-agency approach to meeting children's needs. There are plans to do the same in Whitehaven, although we were told this will be harder logistically because the area is larger.

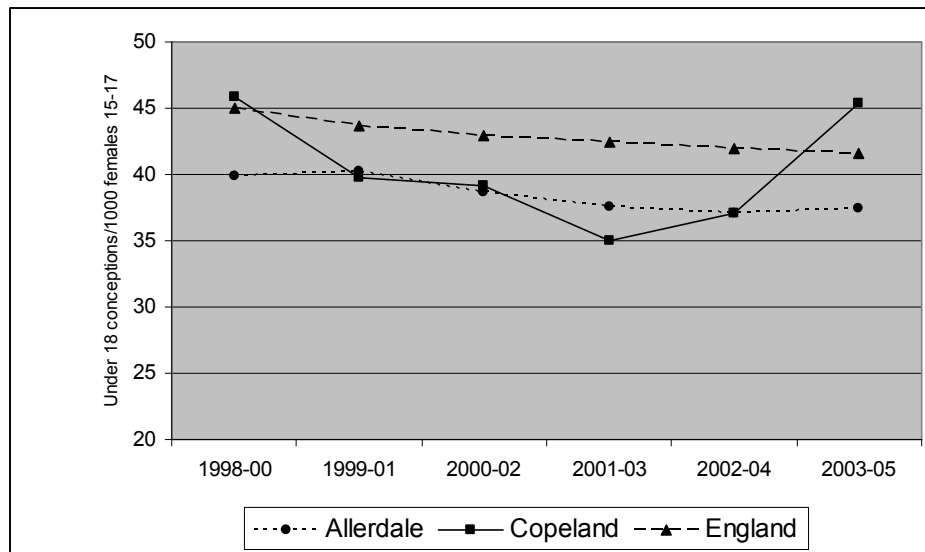
6.7 Children's centres in the two areas provide group activities and individual support for families, often health-focused. An issue was raised in interviews about the PCT withdrawing health workers from the centres, although this is clearly not always the case: the Workington Children's Centre, for example, is co-locating Sure Start and health visitors. This centre runs a range of group activities as well as individual support. However, there is no proactive visit programme; families are either referred or self-refer (following which there will be home visits). The Howgill Family Centre in Whitehaven organises visits to every family with a baby born in Sandwith, Kells, Mirehouse or Harbour, helping them access a range of services. Visits continue for a year. It sometimes takes several visits to make initial contact and an effort is made to engage new parents with group activities, sometimes pairing them with another 'buddy' parent.

6.8 The Flatt Walks surgery in Whitehaven runs a sexual health clinic. We were told that Connexions will offer a Chlamydia testing service in the Family Advice Centre in Woodhouse in the summer.

6.9 Teenage pregnancies were linked by some of our interviewees to dropping out of school. Allerdale's teenage pregnancy rate has remained below the England average since 1999 (see figure 5). In Copeland, however, the teenage pregnancy rate has been rising recently and is now above the England average. The local Teenage Pregnancy Coordinator identified Mirehouse and Sandwith in Whitehaven and Moss Bay and Moorclose in Workington as teenage pregnancy 'hot spots' (they are among the ten wards in Cumbria with the highest rates). Rates in Sandwith and Moss Bay are three times the West Cumbria average, possibly also reflecting local housing allocations. Smoking in pregnancy and emotional and mental health issues are significant problems. New national guidance on teenage pregnancy is being implemented across Cumbria. Teenage parents have access to key workers and group support, and there are two outreach workers for West Cumbria. An initiative is underway to provide a resource pack to all primary schools in the two areas bringing together best practice in sexual health education. There appear to be some issues with

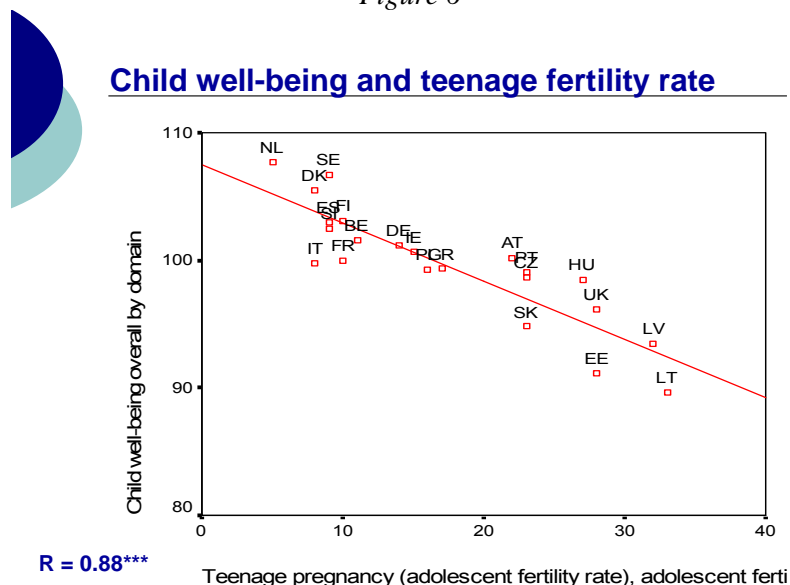
access to sexual health clinics, either because not all schools provide access or there is not easy access to a local clinic.

Figure 5: Teenage conception rate: Allerdale, Copeland and England



6.10 Teenage pregnancies are much more than just a risk factor in themselves. They indicate deeper problems with child well-being. Figure 6 is from research being undertaken by Professor Jonathan Bradshaw at the University of York. It shows not only how the UK's teenage conception rate is very high by European standards, but also how rates across European countries correlate very closely with an overall index of child well-being based on a range of measures, including material situation, housing, subjective well-being, relationships and education.

Figure 6



6.11 We were told that issues with children accessing GPs are not especially evident but this is not the case with dentists, and a substantial number of children are believed not to be registered. Use of A&E and acute care admissions were reported to

be inappropriately high and consuming resources that would be better spent on preventative education with families and schools, and primary care.

6.12 Child and adolescent mental health services (CAMHS) were reported to us as not meeting current needs and being very stretched, with long waits. There are plans to reduce the demand on CAMHS by providing more appropriate support such as learning mentors.

6.13 In summary, there are significant issues of child well-being, especially mental health, in the two areas, which is putting considerable pressure on local schools. The children's centres have a vital role to play in terms of early years support but much more seems necessary for supporting teenagers, including recreational opportunities that offer an alternative to alcohol and getting into trouble, help with mental health issues, and good schooling with the prospect of further education and employment.

7 Discussion and recommendations

Starting upstream

7.1 The root causes of West Cumbria's health problems are the damage to health caused by past industrial employment (resulting in a legacy of chronic conditions), the contemporary weak demand for labour (with resulting worklessness and low pay), and concentrated deprivation. There is likely to be little improvement until the economic fundamentals are right, so economic regeneration of the area to strengthen the demand for labour, together with supply side educational and skills programmes, are vital.

7.2 Even relatively low paid employment is likely to be better for health than long-term benefit dependency, as long as the jobs are of reasonable quality in terms of their security and level of job strain³⁹. Many low paid employees can receive tax credits to increase their incomes and people moving off Incapacity Benefit (IB) can receive time-limited in-work benefits. Low pay, however, will continue to hold back health improvement. Recent national research into the correlation between pay rates and sickness absence suggests that a 1% rise in earnings cuts the rate of sickness by about 0.05% on average⁴⁰.

7.3 Our first recommendation is therefore that **economic regeneration is placed at the heart of health improvement strategies for the two NMIA's**. The main elements of this approach should be both job creation locally and improving access to employment in the travel-to-work area; engagement with employers to promote health and increase skill levels; and engagement with local residents to increase skill levels and support people into work and with staying in employment⁴¹.

7.4 There is a significant effort currently to support IB claimants back into employment but **we recommend, in view of the extent of the NEET issue, educational under-achievement, teenage conceptions and residents' concerns about the lack of opportunities for young people, that regeneration, employment and skills agencies focus on young people, with an intermediate labour market programme for young people most at risk of economic exclusion**⁴².

7.5 This report could advocate an expansion of projects such as healthy food box schemes, cookery groups, green gyms and exercise on prescription, and more smoking cessation clinics. Certainly an expansion of smoking cessation support is essential, not least because there is the opportunity to combine this with the smoking ban in enclosed public places and workplaces, and this is considered further below. Health-damaging behaviours, however, are largely a reflection of the depressed economic conditions in West Cumbria, although they can be addressed in their own right. Socioeconomic inequalities in health are only partly due to lifestyle factors; the fundamental cause is differences in material standards of living. Lifestyle

³⁹ Broom, D. H. *et al* (2006) 'The lesser evil: Bad jobs or unemployment? A survey of mid-aged Australians', *Social Science & Medicine*, 63, pp. 575-586.

⁴⁰ Chisholm, J. (2007) 'Minimum wage has cut sick leave of lowest paid', *Financial Times*, 13 April.

⁴¹ Communities and Local Government (2007) *What works in economic development for deprived neighbourhoods?*

⁴² An example of best practice in this respect is the Team North Huyton intermediate labour market programme as documented on www.renewal.net (accessed May 2007).

interventions to reduce smoking, improve diet and promote physical activity are generally time and labour intensive, and mostly have modest results in isolation from other fiscal and regulatory measures⁴³. They are more likely to have an impact if implemented on a large scale rather than as small projects. **Our approach is to recommend a campaign of mainstreaming healthy practices among employers and retailers, combined with social marketing to influence consumer behaviour.** The should have the following elements⁴⁴:

- Focusing on companies employing local labour or selling goods and services to local residents, recognising good practice with public health awards and 'naming and shaming' bad practice.
- Setting and marketing local targets for the sale and distribution of fruit and vegetables and healthy meals.
- Working with the local public sector to ensure that public procurement reflects public health best practice.
- A social marketing campaign aligned with national initiatives to target messages at key groups such as pregnant mothers and the over-50s⁴⁵.

7.6 While this effort would need to focus on existing organisations in the two areas, major new investments provide the opportunity to mainstream healthy practices from the start, and set examples for others. For instance, a new supermarket opening provides an opportunity to engage with the company regarding both occupational health and promoting healthy lifestyles among its customers. This approach will not be easy and needs high-level support. The LSP should adopt a policy that commits its partners to the approach and recognises South Whitehaven and South Workington NMIA as priority areas for its implementation, alongside the Spearheads areas in Cumbria. Implementation will either need additional resources or redeployment of existing resources. One dedicated public health worker shared between the two NMIA is the minimum investment likely to be needed.

Primary care and active case finding

7.7 There is little doubt that there are substantial numbers of illnesses and deaths in the two NMIA that are preventable with action that is likely to have a relatively fast impact, especially to reduce smoking and control blood pressure and cholesterol⁴⁶. A common theme arising from many of the interviews we carried out was a need to be more proactive in reaching out to people in the community. We encountered calls for GP practices to run clinics or surgeries in the local areas where health needs are highest – often the social housing estates - rather than for people to have to make their way to town centre premises. The Whitehaven NMIA plan refers to an intention to develop one-stop shop Neighbourhood Management Centres in each

⁴³ Jain, A. (2006) 'Treating obesity in individuals and populations', *British Medical Journal*, 331, pp. 1387-90.

⁴⁴ Derived from Lang, T., Dowler, E. and Hunter, D. J. (2006) *Review of the Scottish Diet Action Plan*, Edinburgh: Health Scotland.

⁴⁵ Social marketing is an effective way of reducing the rates of women who smoke before, during and after pregnancy. See Lowry, R., Jordan, C. and Wayman, G. (2002) *Smoking Cessation in Pregnancy – Innovative Success in Sunderland*, Sunderland Teaching Primary Care Trust.

⁴⁶ Department of Health (2006) *Tackling Health Inequalities: 2003-05 data update for the National 2010 PSA Target*, London: DH.

of Sandwith, Kells, Mirehouse and Hensingham⁴⁷. This may be an opportunity to improve access to health care services if clinics can be held in the centres. There seems, however, to be a view among the practices that outreach clinics would not be viable, but **in developing practice based commissioning we recommend that serious consideration is given to how primary care services can reach into these areas to diagnose and address untreated illness**. The availability of pump priming funding is an opportunity to develop outreach work that could generate savings if earlier detection and treatment can be demonstrated. **We also recommend consultation with primary care organisations and the use of performance management and incentivisation to increase statins prescribing, smoking screening and brief interventions, alcohol screening and brief interventions, and risk-based screening of over-50s in the most deprived SOAs**. If progress cannot be made, the PCT should consider options with alternative providers.

7.8 An exemplar in this respect is the Sheffield city-wide initiative for reducing cardiovascular disease (CIRC)⁴⁸. This delivers high-quality, secondary prevention programmes in the city's areas of highest deprivation. The programme set out to identify at least 85% of people in the community with symptomatic CHD so as to deliver a comprehensive programme of secondary prevention to 80% of those in practices with above-average prevalence. CHD teams implemented the programme through four linked action projects:

- Development of protocols and learning manuals
- Training and mentoring programmes
- Support resource packaging
- Specific programmes for South Asian ethnic groups

Fifty-one Sheffield GP practices received a tailored programme of support and this was combined with user support and community engagement. Between 2000 and 2003, a 23% decline in the under-75 cardiovascular mortality rate in the most deprived fifth of Sheffield's population occurred, compared to a 16% decline in the city's population as a whole. The programme has been mainstreamed on the basis of this success.

7.9 The availability of QOF data from GP practices now means that it is possible to compare the distribution at SOA level of CHD prevalence and CHD premature deaths⁴⁹. This enables targeting of work with those practices where death rates are higher than average but where prevalence, as measured by QOF, is lower than expected. Improving QOF performance for CHD should address imbalances in premature deaths.

7.10 In areas of high deprivation it would seem to make sense for advice on welfare benefits to be offered in primary care settings. The issue is therefore whether the withdrawal of CAB services following the end of HAZ funding has negatively impacted on the health of local residents. We report above anecdotal evidence that

⁴⁷ *Building Pride & Respect in South Whitehaven: Neighbourhood Management in South Whitehaven 2006-2010*.

⁴⁸ Department of Health (2005) *Tackling Health Inequalities: what works*, London: DH.

⁴⁹ http://www.pcpoh.bham.ac.uk/publichealth/publications/key_health_data/2005/ch_02.htm

this may be the case. A review of the evidence on welfare advice in primary care published in 2002 found that patients value this service and that most primary care staff appreciate its role⁵⁰. The best available evidence about the impact of such a service on individual health is a multi-site study by Abbott, Hobby and Cotter⁵¹. This found modest improvements in patients' health associated with an income increase as a result of advice and concludes that welfare benefits advice has a role to play for low income patients with chronic conditions.

7.11 We recommend that welfare benefits advice services are provided within primary health care serving the two NMIA's. In view of the problems that may be encountered for some local residents accessing town centres premises, a referral and outreach rather than open access model may be most suitable. Sherratt, Jones and Middleton describe one such service that successfully targeted housebound patients most in need⁵². Many patients entitled to benefits, and who would not otherwise have approached a CAB worker, were referred by primary health care team members. A dedicated telephone line was found to make most efficient use of CAB and primary health care workers' time.

Joining up tobacco control services

7.12 Smoking is the single greatest cause of preventable illness and premature death in the UK. Tobacco control needs a comprehensive approach based on the Department of Health's six strand model:

- Planning and commissioning services
- Making it easier to stop smoking
- Communication (for example, social marketing aimed at specific groups such as pregnant women and school children)
- Multi-agency partnership working
- Tackling underage and illegal availability
- Normalising smoke-free environments
- *Monitoring, evaluation and response*

7.13 Currently, smoking cessation clinics are held in two Whitehaven venues (one NHS) and one Workington venue (NHS), all in the town centres. Smoking cessation services in West Cumbria have been under-resourced for some time but the situation is now improving with new appointments. Whether this will provide the capacity necessary to achieve the national smoking prevalence target of 26% among routine and manual groups by 2010 is unknown. A recent health equity audit of smoking cessation services in North Cumbria demonstrated that areas of higher deprivation were seeing less success with achieving cessation, so it is important that the extra workers target these areas, which clearly include South Whitehaven and South

⁵⁰ Greasley, P. and Small, N. (2002) *Welfare advice in primary care*, Nuffield Portfolio Programme Report No. 17, School of Health Studies, University of Bradford.

⁵¹ Abbott, S., Hobby, L. and Cotter, S. (2006) 'What is the impact on individual health of services in general practice settings which offer welfare benefits advice?', *Health & Social Care in the Community*, 14 (1), 1-8. .

⁵² Sherratt, M., Jones, K. and Middleton, P. (2000) 'A citizens' advice service in primary care: improving patient access to benefits', *Primary Health Care Research & Development*, 1, 139-146.

Workington⁵³. However, the approach needs to be right if these services are to have the highest health impact possible within the resources available. **We recommend that the planning and commissioning of smoking cessation services is reviewed in the light of best practice.** An initial checklist is:

- Do local residents have access to a choice of one-to-one, group and drop-in clinics with trained advisors?
- Are these clinics provided at a variety of locations, including GP practices, community centres and leisure centres?
- Are clinics held on different days and at various times to ensure the maximum number of users can attend?
- Is training provided in brief interventions to both health and partner organisations?
- Are data on service users collected, and collated and analysed centrally?
- Are services performance-managed to achieve the highest quit rates in the SOAs with the highest deprivation?

Some of this is currently under development utilising NLDC funding but it will be important to mainstream these approaches as far as possible, and to monitor and evaluate implementation.

7.14 One of the groups in society with the highest smoking prevalence is people receiving Incapacity Benefit (this may be linked to mental health issues). Jobcentre Plus in West Cumbria refers clients for help with their health or disability problems, both as claimants and while supported in work. Extra support can be accessed from specialist services such as drug and alcohol treatment services. **We strongly encourage current steps to train personal advisors in offering brief interventions to help clients stop smoking, improve their health and prepare for smoke-free workplaces.** If smoking cessation and employment advisers can be based in GP practices there is obviously potential for cross-referral.

Healthy housing and neighbourhoods

7.15 Efforts to normalise smoke-free environments should extend to the home. There is currently a programme of home safety checks run by the Fire Service in both areas. These should include leaving residents with information about smoking cessation services. Tenants of RSLs in the two areas are a major target group for smoke-free home initiatives, given the high prevalence among this group. Some developments are already in hand with registered social landlords but **we recommend full implementation of a Smoke Free Homes Campaign aimed at encouraging residents to ban smoking in their homes to protect non-smokers from secondhand smoke (especially children) and encourage cessation among those who do smoke.** This can be based on postcards that people display in their homes, as described in a recent report in *Local Government Chronicle* on Leicester's Smoke Free Homes Campaign⁵⁴:

⁵³ *Health Equity Audit of North Cumbria Smoking Cessation Service.*

⁵⁴ *Local Government Chronicle*, 11 January 2007, p. 17.

‘The project designed double-sided postcards bearing the motto “We love our smoke-free home” for people to display in their homes or give out to visitors and relatives. The postcards also served as an educational tool, with key facts about smoking such as “more dogs and cats die of cancer in smoky homes” and “children and babies are more likely to develop asthma” ... The postcards have proved to be incredibly popular’.

7.16 We recommend that every effort is made to prioritise heating improvements and insulation in all tenures. This is likely to be the single most important housing intervention that can improve health in the two areas. Inadequate insulation or heating can cause cold-related medical problems that affect all age groups but especially older people. All fuel poor households should be targeted and, in the longer term, all energy inefficient properties. Programmes should tackle serious draughts, defects and faults; achieve optimal ventilation while minimising heat loss; include special measures to tackle fuel poverty among hard-to-reach groups, and provide advice on benefits and how to operate new heating systems (especially for older people). There should be a proactive use of powers to improve the energy efficiency of private sector homes.

7.17 Copeland Homes and Derwent & Solway are key players in housing market renewal. The current lack of suitable housing for older people should be addressed through these programmes given that unsuitable properties present risks of accidents and depression. While housing market renewal is likely to deliver a significant health gain, there is a clear risk to residents’ health from uncertainty, disruption and possible delays. The Whitehaven NMIA explicitly recognises this, with a commitment to ensuring that socially and physically the neighbourhoods are supported during what will be several years of redevelopment, mainly by deploying neighbourhood wardens. **We recommend that this support includes special measures to involve hard-to-reach groups such as older people to help avoid anxiety and stress. Improvement works need to be well-managed with an explicit and publicised commitment to minimise disruption for residents.**

7.18 Copeland Homes and D&S are leading work on bringing social housing up to the decent homes standard. Current rates of decent homes in their stocks are 48% and 70% respectively⁵⁵. **We recommend that work on bringing homes up to the decency standard includes providing tenants with a resource pack that includes advice about healthy cooking and family eating, quitting smoking and smoke-free homes, walking and workouts, and keeping warm**⁵⁶.

7.19 D&S will apply an enhanced standard after 2010 that involves extra investment in tenants’ homes and the local area. **We recommend universalising this standard in the two NMIA as a ‘decent neighbourhood standard’ that incorporates walkability (pleasant routes, clean streets, safe environments) and access to healthy food (either local shops recognised for their affordable healthy food range or good public transport links to shops offering the same).** The standard should be complemented by a programme of estate walkabouts by local

⁵⁵ West Cumbria LSP Annual Review 2005-06 *Housing*.

⁵⁶ This is modelled on Stockton’s Shape up with your Family project, reporting in *Local Government Chronicle*, 11 January 2007. By the end of this scheme, 78% of participants had lost 3-5% of their start weight.

housing assistants with local residents. It should be informed by evidence about neighbourhood effects on health, and include trees, greenery and community safety measures. The standard could also include whether the local primary schools accord with best practice, since these are key neighbourhood resources. This could include⁵⁷:

- Specific measures that engage parents in their children's learning
- A breakfast club
- Specific healthy food and water intake initiatives
- A walking bus
- School nurse provision that includes weekly drop-ins and the opportunity for parents to meet the school nurse informally
- Sex and relationship education workshops for parents
- Smoke-free school and grounds

7.20 There appears to be variability in the extent to which community health services are co-located with children's centres and how far local schools engage with health improvement activities, including the support they receive. Overall, **we recommend that there is a review of community venues in the two NMIs with a view to achieving better integration and local access to health care, smoking cessation support, employment services and advice about benefits, housing and insulation.** This should include joint training initiatives, such as skilling community development workers and youth workers in health education and brief interventions.

⁵⁷ Based on Petteril Bank Community Primary Extended School as documented on www.renewal.net (accessed May 2007).

Appendix 1: List of documents consulted

- Abbott, S., Hobby, L. and Cotter, S. (2006) 'What is the impact on individual health of services in general practice settings which offer welfare benefits advice?', *Health & Social Care in the Community*, 14 (1), 1-8.
- Blackman, T. (2006) *Placing Health: Neighbourhood renewal, health improvement and complexity*, Bristol: Policy Press.
- Broom, D. H. *et al* (2006) 'The lesser evil: Bad jobs or unemployment? A survey of mid-aged Australians', *Social Science & Medicine*, 63, pp. 575-586.
- Building Pride & Respect in South Whitehaven: Neighbourhood Management in South Whitehaven 2006-2010.*
- Building Pride & Respect: Neighbourhood Management in South Workington Delivery Plan.*
- Casebourne, J., Davis, S. and Page, R. (2006) *Review of Action Teams for Jobs*. Department for Work and Pensions Research Report No. 328. London: DWP.
- Clay, J. (2006) *North Cumbria: Hospital Admissions for Alcohol Specific Conditions*. Cumbria Primary Care Trust.
- Communities and Local Government (2007) *What works in economic development for deprived neighbourhoods?*
<http://www.renewal.net/Documents/RNET/Research/Whatworkseconomicdevelopment.pdf>
- Cumbria County Council (2006) *Cumbria Quality of Life Survey 2006*.
- Department of Health (2005) *Tackling Health Inequalities: what works*, London: DH.
- Department of Health (2006) *Tackling Health Inequalities: 2003-05 data update for the National 2010 PSA Target*, London: DH.
- DfES Schools and Colleges Attainment and Achievement Tables
<http://www.dfes.gov.uk/performance/tables/>.
- DWP benefits data <http://www.dwp.gov.uk/asd/tabtool.asp>.
- Greasley, P. and Small, N. (2002) *Welfare advice in primary care*, Nuffield Portfolio Programme Report No. 17, School of Health Studies, University of Bradford.
- Health and housing risk assessment tool
http://changeagentteam.org.uk/_library/docs/Housing/Housingandhealth/Health_and_housing_assessment_tool.pdf.
- Health Equity Audit of North Cumbria Smoking Cessation Service.*
- Jain, A. (2006) 'Treating obesity in individuals and populations', *British Medical Journal*, 331, pp. 1387-90.
- Kemp, P. A., Sunden, A. and Tauritz, B. B. (2006) *Sick Societies? Trends in disability benefits in post-industrial welfare states*, Geneva: International Social Security Association.
- Lang, T., Dowler, E. and Hunter, D. J. (2006) *Review of the Scottish Diet Action Plan*, Edinburgh: Health Scotland.
- Lowry, R., Jordan, C. and Wayman, G. (2002) *Smoking Cessation in Pregnancy – Innovative Success in Sunderland*, Sunderland Teaching Primary Care Trust.
- Morleo, M., Dedman, D., Hughes, K., Hooper, J., Tocque, K. and Bellis, M. A. (eds), *Regional Alcohol Indicators for the North West of England 2006*, Main Report. North West Public Health Observatory.
- NOMIS official labour market statistics < <http://www.nomisweb.co.uk/>>.
- Office of National Statistics. *Life Expectancy at Birth for Wards in England and Wales*. <<http://www.statistics.gov.uk/statbase/Product.asp?vlnk=14466>>.
- Pearce, D. (2004) *North Cumbria Health and Lifestyle Survey*, Cumbria PCTs.

QOF database 2006 QOF Database 2006.
 <<http://www.gpcontract.co.uk/search.php?year=6>>.

Sherratt, M., Jones, K. and Middleton, P. (2000) 'A citizens' advice service in primary care: improving patient access to benefits', *Primary Health Care Research & Development*, 1, 139-146.

Strategy for Sustainable Communities in West Cumbria 2007-2020 Draft for Discussion, February 2007.

West Cumbria LSP Annual Review 2005-06 *Housing*.

Appendix 2: List of people interviewed

Anita Barker, Practice Based Commissioning, Cumbria PCT
Steve Blyth, Employment Engagement Manager, Jobcentre Plus, Workington
Anne Bradshaw, local councillor, Whitehaven
Sheila Brannon, Duty Manager, Tesco, Whitehaven
Catherine Burkes, Adviser Services Manager, Jobcentre Plus, Workington
Rowland Burns, Housing Services Section Team Leader, Allerdale Council
Barbara Cannon, Chair of NMIA Board and local councillor, Workington
John Cass, Community Regeneration Manager, Copeland Homes
Ann Chambers, Howgill Family Centre, Whitehaven
Angus Christie, Queen Street GP, Whitehaven
Christine Clark, Local Teenage Pregnancy Co-ordinator, West Cumbria
Jan Clarke, Health Schools Co-ordinator, West Cumbria
Steph Crossway, Workington Children's Centre
Mrs Dalkin, Head teacher, Southfield Technology College, Workington
Gill Davidson, Lowther Medical Centre, Whitehaven
Greg Denwood, Head of Development and Regeneration for Home North West, Copeland Homes
Pauline Eppy, Teacher, Victoria Junior School, Workington
Diane Gorge, Housing Needs Officer, Allerdale Council
Carol Graham, Manager of Citizen's Advice Bureau, Whitehaven
Nik Hardy, local councillor, Workington
Chris Horton, Personnel Manager, Tesco, Workington
Cath Howard, Employment Support Project, Copeland
Nicola Kitchen, Cumbria PCT
Jane Little, Solway Health Services, Workington
Katrina MacEwan, Family Advice Centre, Whitehaven
Anne Maudling, local resident and NMIA board member, Whitehaven
Susan McKenzie, Jobcentre Plus, Workington
John McVay, Fire Service
Rob Meritt, Pulse, Whitehaven
Chris Nicholson, District Nurse Sister, Whitehaven
Keith Parker, Head of Leisure and Environment Services, Copeland Council
Jill Payne, Operational Support, Jobcentre Plus, Workington
Ian Payne, Head of Environment, Allerdale Council
Salli Pilcher, Senior Clinical Manager, Cumbria PCT
Robert Porter, Director, Derwent and Solway
Mike Priestley, Connexions, Whitehaven
Hillary Reay, Head Teacher, Valley Primary School, Whitehaven
Lesley Sanczuk, Area Manager for Education and Welfare, Children's Services and Local Planning Group Project Manager, West Cumbria
Emma Smith, Senior Clinical Manager, Workington, Cumbria PCT
Linda Steel, Oxford Street Surgery, Workington
Mark Stokes, Manager, Debenhams, Workington
Nik Storey, Tobacco Control Co-ordinator, Cumbria PCT
Martin Telford, Manager of Citizen's Advice Bureau, Allerdale
Mike Tichford, Head of Regeneration, Copeland Borough Council
Linda Williamson, Advisory service manager, Jobcentre Plus, Whitehaven

Appendix 3: Interview schedule for service providers

Geographical coverage of service/responsibility

Main aims of the service/responsibility

How do health problems in the Neighbourhood Management area affect your service/responsibility?

Objectives regarded as relevant to *improving people's health* in the NM area (preventative stuff)

Prompt regarding any health problems not mentioned (smoking, exercise, food, IB – mental health and musculoskeletal problems)

Criteria by which beneficiaries/clients are selected (including any specific outreach/case finding work) (what are they doing to find people?)

Contact with beneficiaries/clients (e.g. pathways, consultation)

Strategies by which aims and objectives are met relevant to residents in the NM area

Specific health-related strategies or projects

Evidence of effectiveness of current health-related work

Barriers to achieving aims and objectives

Other organisations with which collaborate and nature of collaboration

Monitoring information available?

Ideas not mentioned so far about how health impact could be increased for own service/responsibility (i.e. what could they be doing that they aren't?)

Ideas not mentioned so far about how health impact could be increased for other services/responsibilities that impinge on own service/responsibility

Interview schedule for Primary Care Practices

Probe for each question whether there is anything specific to the Workington or Whitehaven NMA to add

What, in summary, are the main health problems your practice encounters?

What work is the practice doing to ensure that those with disease or at high risk in your area are accessing treatment and prevention services?

Do you use prevalence models to inform case-finding?

Are there any problems with you being able to make appropriate prescriptions of statins, aspirins and beta blockers?

What work is the surgery doing to promote lifestyle changes to improve patients' health, such as physical activity and 5-a-day?

What links do you have with:

Smoking cessation services	Are they working well? (examples)
----------------------------	-----------------------------------

Housing services	Are they working well? (examples)
------------------	-----------------------------------

Leisure and sport amenities	Are they working well? (examples)
-----------------------------	-----------------------------------

Social services	Are they working well? (examples)
-----------------	-----------------------------------

Sexual health services	Are they working well? (examples)
------------------------	-----------------------------------

Alcohol treatment services	Are they working well? (examples)
----------------------------	-----------------------------------

Health trainers	Are they working well? (examples)
-----------------	-----------------------------------

Welfare rights/money advice	Are they working well? (examples)
-----------------------------	-----------------------------------

Jobcentre Plus	Are they working well? (examples)
----------------	-----------------------------------

Do you have any particular problems with maternal smoking and what are you trying to do about it?

Is there a problem of lack of awareness of symptoms and screening services? What is being done about this?

Does the practice have a policy about alcohol screening? If yes, details.

Are there are particular barriers to patients accessing your services, perhaps for some patients more than others?

Do you have a problem with no-shows for appointments? Is there any particular type of patient involved?

Could more be done to involve people with health checks?

Are there any problems with liaison between primary care and specialists? (what specialists work from the primary care premise?)

Do you feel there are any issues with people's aspirations for their health?

What more could be done to improve the quality of primary care in the Workington/Whitehaven NR areas?

What do you do to benchmark your practice's work against best practice in primary care, especially for those with the worst health and deprivation?

Interview schedule for employers

Problems with people off sick?

What do they do to help people get back to work?

What more could be done?

Barriers to doing it?

Problems getting staff/retaining them?

Healthy eating and lifestyle promotion in store.

Interview schedule for residents/members of NMIA Board

Main issues in NM area as you see them, specifically re housing, worklessness and access to primary care

Existing services in NM area

What more could be done/way forward

Barriers

Good practice elsewhere

Partnership working

Interview schedule for schools

How do health problems in the Neighbourhood Management area affect your service/responsibility?

Objectives regarded as relevant to *improving people's health* in the NM area (preventative)

Prompt regarding any health problems not mentioned (smoking, exercise, food, IB – mental health and musculoskeletal problems)

Specific health-related strategies or projects (e.g. after school clubs/breakfast clubs, elaborate including any issues/problems, e.g. take-up, funding).

School meals/healthy eating

Evidence of effectiveness of current health-related work

Barriers to achieving aims and objectives

Other organisations with which collaborate and nature of collaboration

What links do you have with:

Housing services	Are they working well? (examples)
Leisure and sport amenities	Are they working well? (examples)
Social services	Are they working well? (examples)
Sexual health services	Are they working well? (examples)
Welfare rights/money advice	Are they working well? (examples)

Ideas not mentioned so far about how health impact could be increased for own service/responsibility (i.e. what could they be doing that they aren't?)

Ideas not mentioned so far about how health impact could be increased for other services/responsibilities that impinge on own service/responsibility

Interview schedule for CAB

Working with GPs in area? If not, why did they stop? Any further plans to restart/expand this service?

Geographical coverage of service/responsibility

Main aims of the service/responsibility

How do health problems in the Neighbourhood Management area affect your service/responsibility?

Objectives regarded as relevant to *improving people's health* in the NM area (preventative stuff)

Prompt regarding any health problems not mentioned (smoking, exercise, food, IB – mental health and musculoskeletal problems)

Criteria by which beneficiaries/clients are selected (including any specific outreach/case finding work) (what are they doing to find people?)

Contact with beneficiaries/clients (e.g. pathways, consultation)

Strategies by which aims and objectives are met relevant to residents in the NM area

Specific health-related strategies or projects

Evidence of effectiveness of current health-related work

Barriers to achieving aims and objectives

Other organisations with which collaborate and nature of collaboration

Monitoring information available?

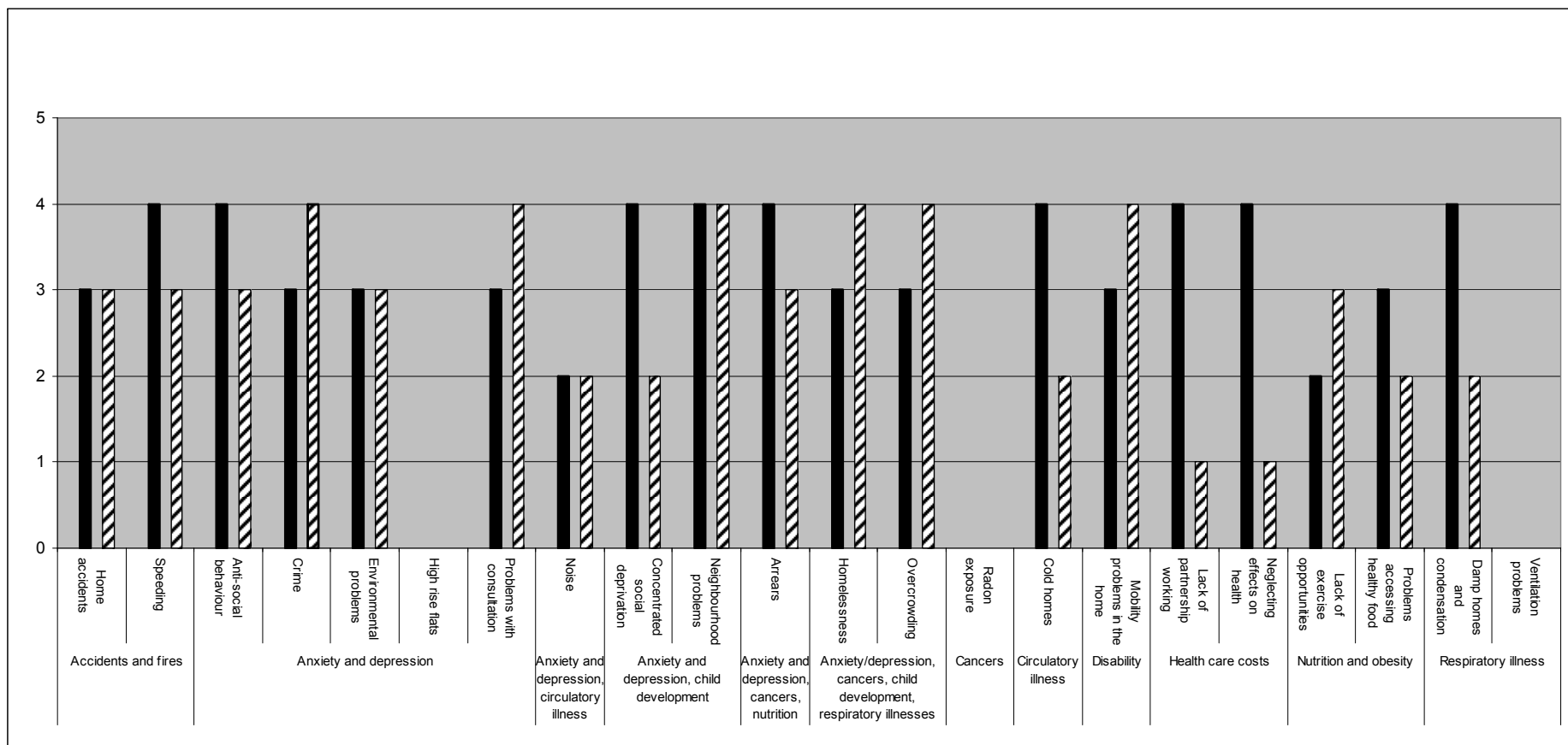
Ideas not mentioned so far about how health impact could be increased for own service/responsibility (i.e. what could they be doing that they aren't?)

Ideas not mentioned so far about how health impact could be increased for other services/responsibilities that impinge on own service/responsibility

Appendix 4a. Housing and health risks and practices: South Workington NMIA

Solid bar = severity of problem (0=don't know; 1=absent; 2=very rare; 3=quite rare; 4=fairly common; 5=very common)

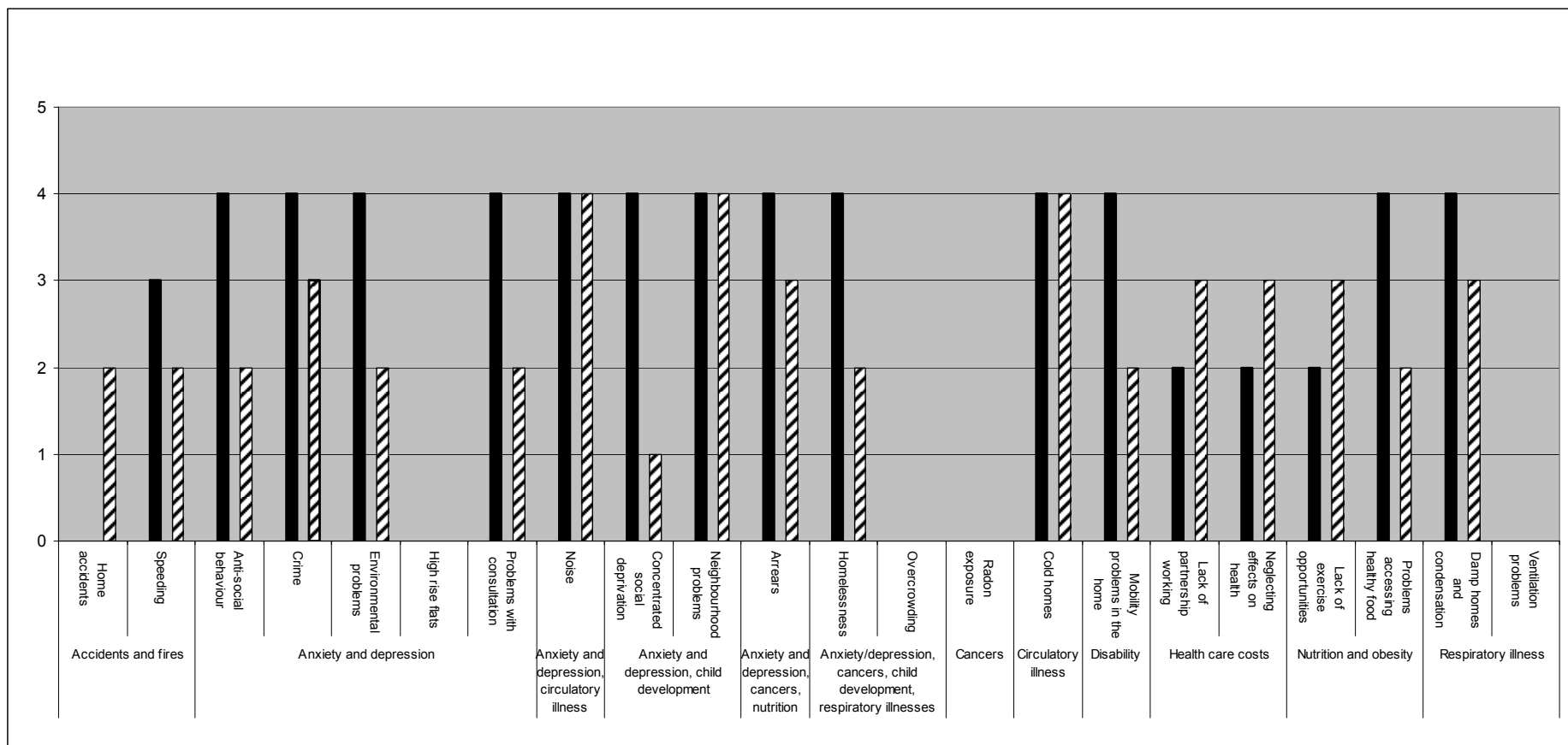
Striped bar = assessment of practice (0=don't know; 1=needs a lot of development; 2=needs some development; 3=adequate; 4=well developed; 5=very well developed)



Appendix 4b. Housing and health risks and practices: South Whitehaven NMIA

Solid bar = severity of problem (0=don't know; 1=absent; 2=very rare; 3=quite rare; 4=fairly common; 5=very common)

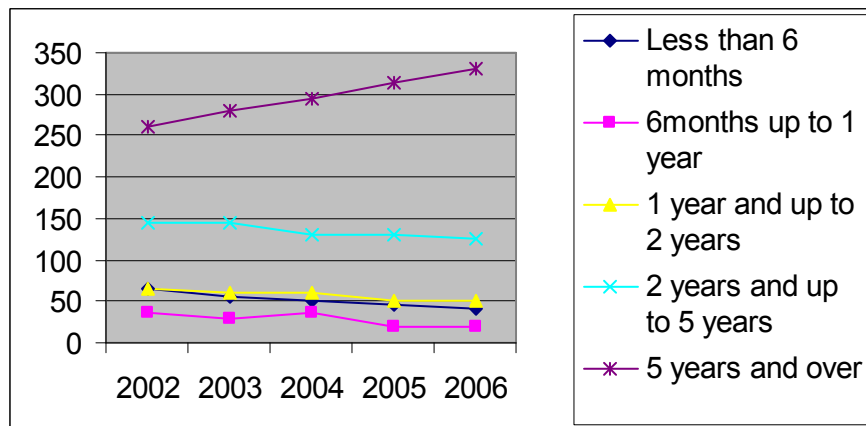
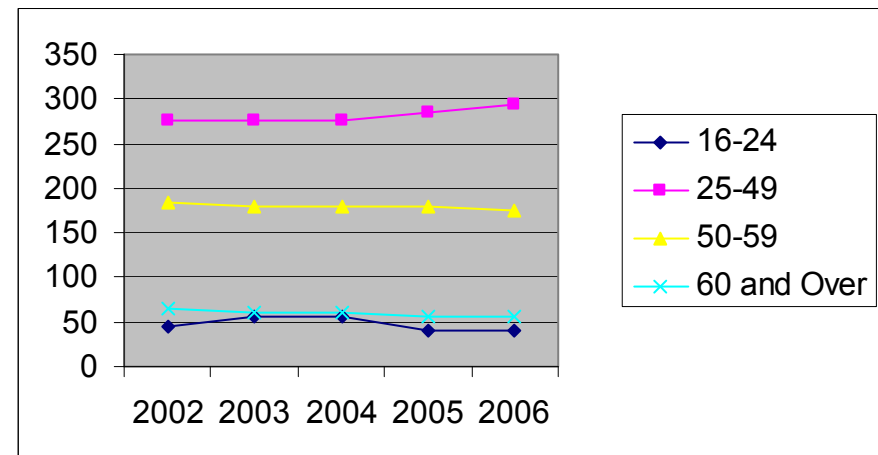
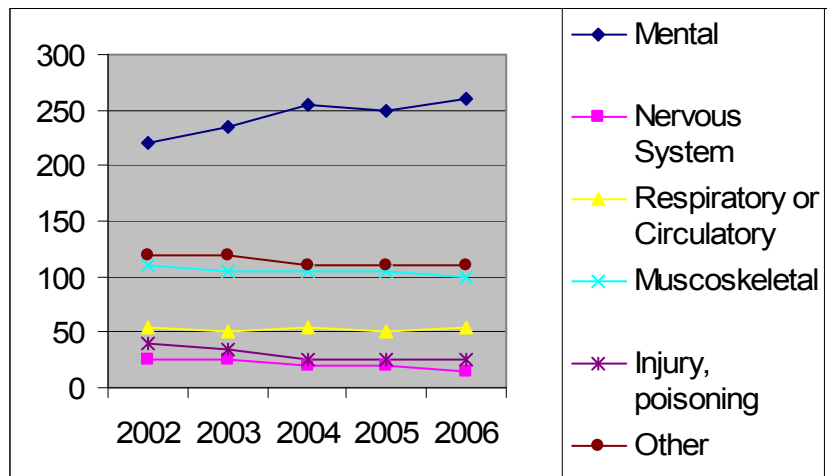
Striped bar = assessment of practice (0=don't know; 1=needs a lot of development; 2=needs some development; 3=adequate; 4=well developed; 5=very well developed)



Appendix 5

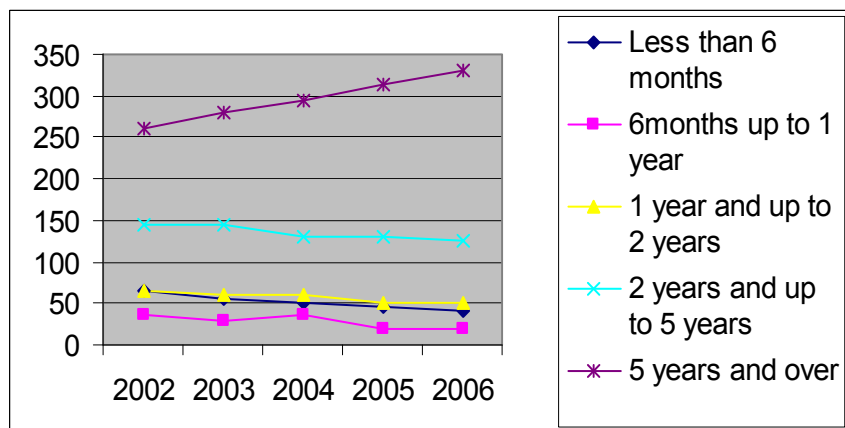
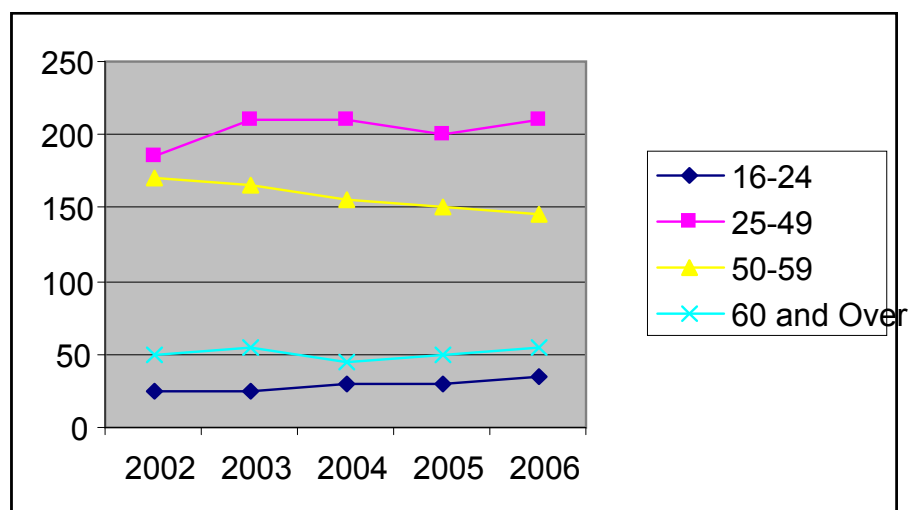
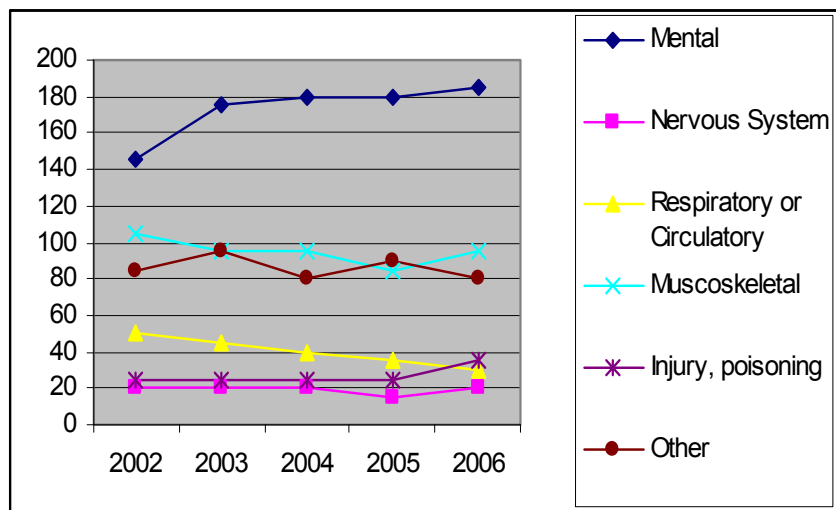
Incapacity Benefit/Severe Disablement Allowance Claimants: Moss Bay, Allerdale

Year	Aug 2002	Aug 2003	Aug 2004	Aug 2005	Aug 2006
Total IB/SDA	570 (60.5% male)	570 (57.9% male)	570 (57.9% male)	560 (57.1% male)	565 (57.5% male)



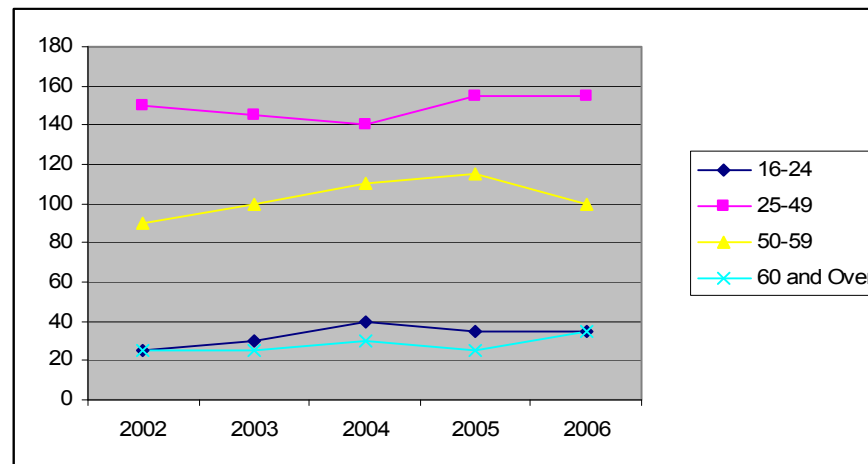
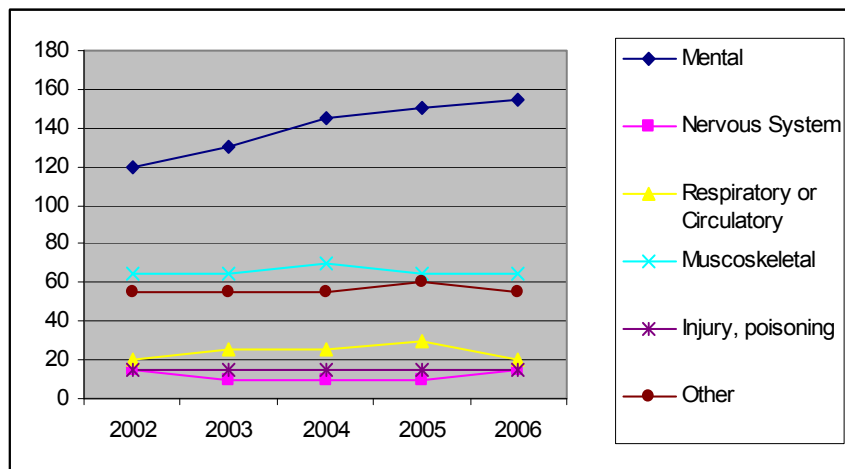
Incapacity Benefit/Severe Disablement Allowance Claimants: Moorclose, Allerdale

Year	Aug 2002	Aug 2003	Aug 2004	Aug 2005	Aug 2006
Total IB/SDA	430 (55.8% male)	455 (54.9% male)	440 (54.5% male)	430 (57.0% male)	445 (55.1% male)



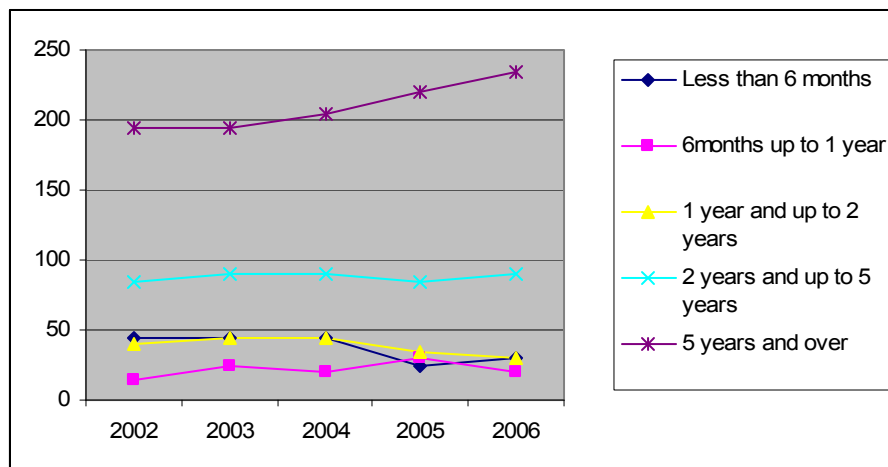
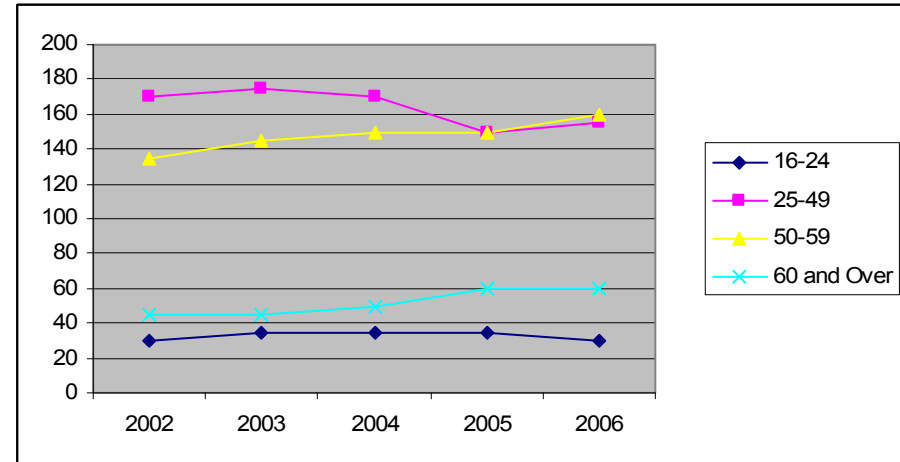
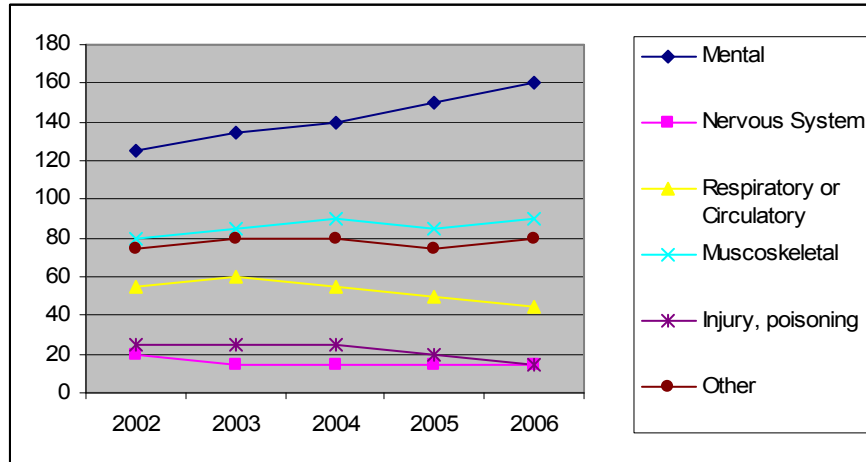
Incapacity Benefit/Severe Disablement Allowance Claimants: Sandwith, Copeland

Year	Aug 2002	Aug 2003	Aug 2004	Aug 2005	Aug 2006
Total IB/SDA	290 (63.8% male)	300 (63.3% male)	320 (65.6% male)	330 (63.6% male)	325 (64.6% male)



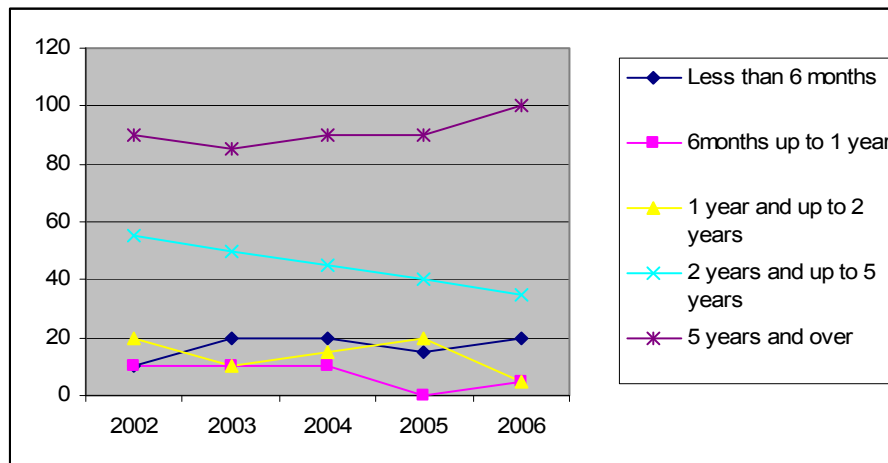
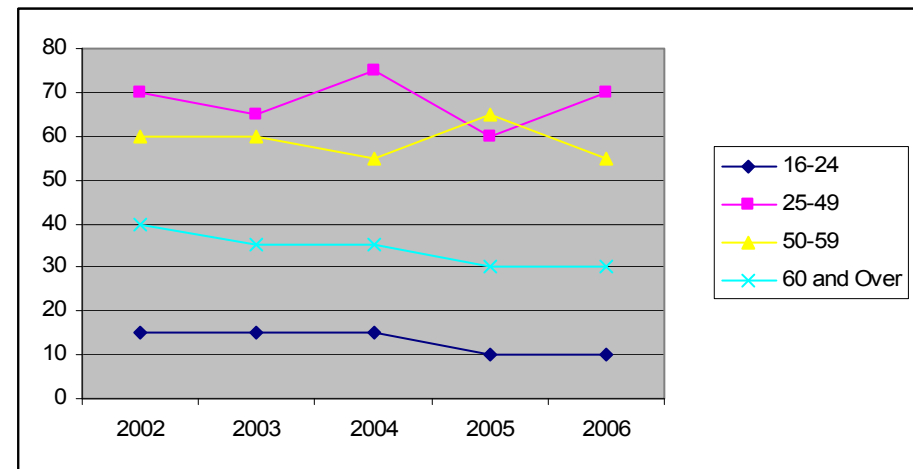
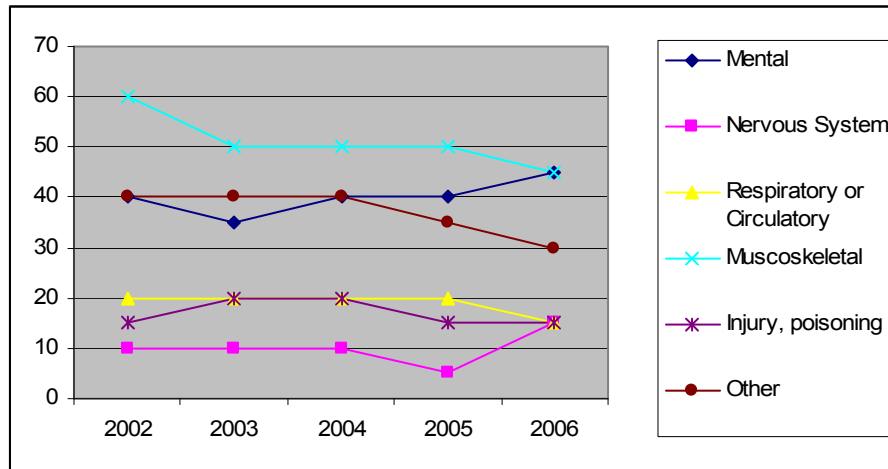
Incapacity Benefit/Severe Disablement Allowance Claimants: Mirehouse, Copeland

Year	Aug 2002	Aug 2003	Aug 2004	Aug 2005	Aug 2006
Total IB/SDA	380 (64.5% male)	400 (66.3% male)	405 (64.2% male)	395 (63.3% male)	405 (63.0% male)



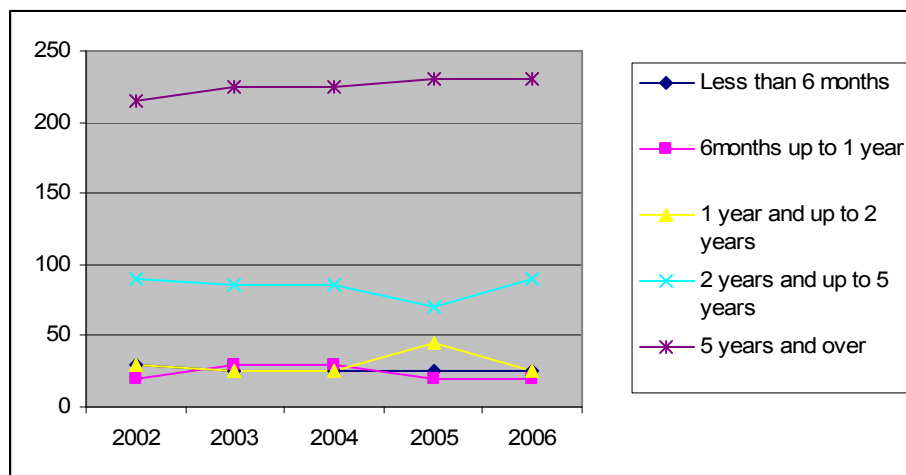
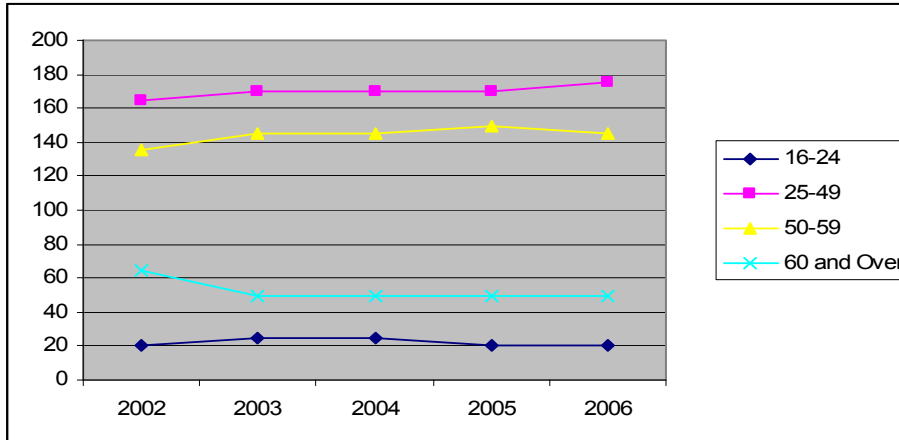
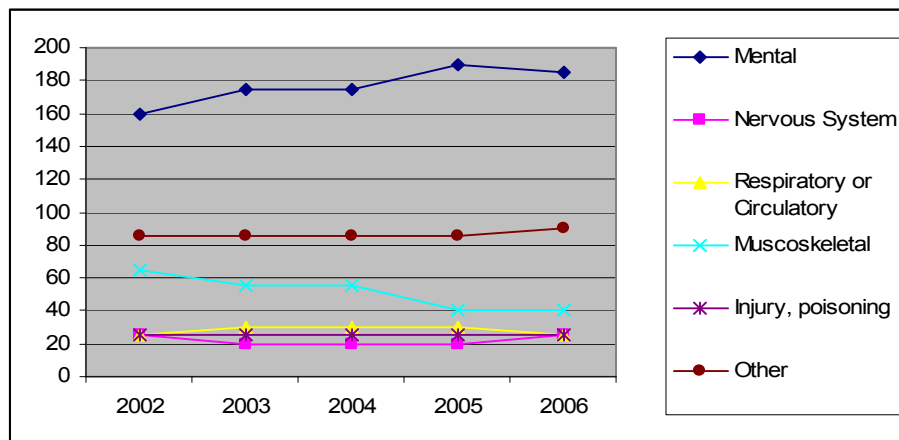
Incapacity Benefit/Severe Disablement Allowance Claimants: Kells, Copeland

Year	Aug 2002	Aug 2003	Aug 2004	Aug 2005	Aug 2006
Total IB/SDA	185 (67.6% male)	175 (68.6% male)	180 (63.9% male)	165 (60.6% male)	165 (63.6% male)



Incapacity Benefit/Severe Disablement Allowance Claimants: Harbour, Copeland

Year	Aug 2002	Aug 2003	Aug 2004	Aug 2005	Aug 2006
Total IB/SDA	385 (68.8% male)	390 (66.7% male)	390 (66.7% male)	390 (67.9% male)	390 (67.9% male)



Incapacity Benefit/Severe Disablement Allowance Claimants: Hensingham, Copeland

Year	Aug 2002	Aug 2003	Aug 2004	Aug 2005	Aug 2006
Total IB/SDA	300 (63.3% male)	290 (58.6% male)	290 (58.6% male)	295 (59.3% male)	285 (57.9% male)

